Department of Medicine

"AS THE CHAIRMEN SAW IT"

VOLUME TWO

Department of Medicine "AS THE CHAIRMEN SAW IT"

THE UNIVERSITY OF ALBERTA

DEPARTMENT OF MEDICINE

"AS THE CHAIRMEN SAW IT"

Volume Two

In an ongoing series of histories by former
Chairmen of the Department of Medicine

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INDEX PAGE

PREAMBLE 1

AUTOBIOGRAPHICAL NOTES
PERSONAL BACKGROUND 2
ROLE MODELS 4

HISTORY OF THE DEPARTMENT
PRIOR TO 1975 13
DEVELOPMENTS 1975-1986 15

ISSUES AND CONCERNS
ADMINISTRATION 33
ACADEMIC CLINICAL PRACTICE 43
TEACHING 45
RESEARCH 53

CREDITS 67

CONCLUSION 87

ACKNOWLEDGEMENTS 88

TABLES
1 TEACHING, RESEARCH AND PRACTICE WITHIN THE DEPARTMENT OF MEDICINE IN 1977 34
2 ADMINISTRATIVE AND ORGANIZATIONAL STRUCTURE IN EDMONTON TEACHING HOSPITALS IN 1977 36
3 COMPOSITION AND LOCATION OF STAFF DEPARTMENT OF MEDICINE 1976-77 (1985-86) 38
4 DEPARTMENT OF MEDICINE BED DISTRIBUTIONS UAH—1977-1985 42

FIGURES
1 UNIVERSITY OF ALBERTA - DEPARTMENT OF MEDICINE ORGANIZATION CHART 27
2 FULL-TIME ACADEMIC STAFF DEPARTMENT OF MEDICINE 32
3 GRADUATE STUDENT ENROLLMENT IN THE DEPARTMENT OF MEDICINE 65

APPENDICES 89
I ACADEMIC STAFF MEMBERSHIP IN 1974 AND CHANGES YEAR-BY-YEAR 90-104
II COMMITTEES AND THEIR MEMBERSHIPS 105-113
III CHIEFS OF MEDICINE AFFILIATED TEACHING HOSPITALS . 114
IV DIVISIONAL DIRECTORS 115
V CHIEF MEDICAL RESIDENTS 116
VI RECOGNITION OF TEACHING EXCELLENCE 117
VII HONOURS AND AWARDS 118-120
VIII COMPENSATION OF PART-TIME STAFF 121
VIIIB RANK COMPENSATION FOR PART-TIME STAFF 122
VIIIC TEACHING TIME CATEGORIES FOR PART-TIME STAFF 123
VIIID CALCULATION AND RECOMMENDATION OF SALARY FOR PART-TIME STAFF 124

PREAMBLE

I became the fifth Chairman during the sixth decade of the Department of Medicine's existence. With three of my four predecessors alive and available, I felt the importance of the opportunity to have them create a first-hand account of the Department's origins and history. Dr. Egerton L. Pope, the first Head, the Chairman equivalent of the time, was long dead. However, Drs. John W. Scott, Donald R. Wilson and Robert S. Fraser all agreed to write the story of the Department of their times. Now my turn to report has come.

While Drs. Scott and Wilson provided factual, vivid accounts of their times and stewardship focused on the University of Alberta, their successor Dr. Fraser provided a more detailed account of both what went on in and about the Department of Medicine, and the University of Alberta as well as what happened in our province, in Canada and indeed in the world, during his chairmanship.

For my part I propose to account for the facts and events of 1975 to 1986 within the Department of Medicine and in the much smaller world directly or indirectly affecting our particular portion of the University of Alberta and its Faculty of Medicine.

However, I also plan to sketch in the major relevant trends of these years in terms of principles, philosophies and policies; for instance, the controversies which swirled in and around the Department concerning the roles and training of generalists versus subspecialists in Internal Medicine. Concerning these trends I propose to deal with education and training and teaching approaches as well as clinical practice and research. In the last-mentioned area, the increasing importance of molecular biology and immunology and the ever-closer

scrutiny of clinical research are examples of trends worthy of mention.

I plan not to shy away from recording my personal background and the development of my principles and attitudes which guided me during these years in the fields of education, research, clinical practice and administration. Without these aspects of my chairmanship, this account of the Department of Medicine during the years of 1975 to 1986 would be not only incomplete but also impersonal indeed.

AUTOBIOGRAPHICAL NOTES

PERSONAL BACKGROUND

Some aspects of my personal background are relevant. I had just completed a year of college education at Mount Royal College in Calgary by May of 1942 when I enlisted in the Canadian Army. In October of 1945 I was discharged with the rank of Captain having served in Britain, Sicily, Italy and northwest Europe. I entered the University of Alberta's January 1946 pre-medical class. After admission to the Faculty of Medicine in 1948 I obtained my Bachelor of Science and Medicine degrees in 1949 and 1951 respectively, in each instance with first class distinction. I was awarded the gold medal in both Medicine and Surgery upon graduating with the M.D. degree.

Following a year of internship at the University of Alberta Hospitals, I went to the Mayo Clinic (and thereby to the Mayo Graduate School of Medicine of the University of Minnesota in Rochester) for training in Internal Medicine, with recommendations from Drs. Walter Mackenzie and D.R. Wilson, my professors of Surgery and Medicine. Both men were to be influential 23 years later in encouraging me to return to the University of Alberta

to the Chair of the Department of Medicine.

At Mayo I eventually elected the subspecialty field of Endocrinology and Metabolism. I had the good fortune of having Drs. Alexander Albert and F. Raymond Keating as the supervisors of my research training. This led to my Ph.D. degree which I obtained from the University of Minnesota in 1956. My Ph.D. thesis project involved the development and application of an in vitro technique for the study of surviving human thyroid slices with radioactive iodine. This method was a forerunner of the various subsequent widely used perifusion techniques. It allowed for precise analysis of cellular events in both animal and human surgical thyroid specimens both normal and in various pathologic states.

In 1956 I became a member of the Mayo Clinic staff as a consultant in Internal Medicine and Endocrinology and Metabolism. From the initial rank of instructor I rose to the rank of Professor (1971) in the Mayo Graduate School of Medicine and upon the establishment of Mayo Medical School (1973) in it as well.

From initial investigative efforts in thyroid and adrenocortical, as well as other endocrine and metabolic problems, I changed my focus to diabetes mellitus by the early 1960's. With some excellent colleagues on the Mayo staff, as well as an outstanding group of graduate students and funding from the National Institutes of Health, I had the good fortune to study patients in such detail in a metabolic ward setting, that we could discover, define and analyze some of the hitherto elusive aspects characterizing unstable and stable diabetes. Through continuous automated glucose monitoring of continuously withdrawn blood by means of indwelling catheters, we could define both carbohydrate and some relevant hormonal parameters and their fluctuations and inter-relationships in our research

volunteers. Reports of this work led to interest and international recognition of the new knowledge we provided. I was, of course, pleased to note that the University of Alberta also took note of my progress.

The first sign of interest in my consideration for the University of Alberta's Department of Medicine Chairmanship came from Dr. Walter Mackenzie in the fall of 1973. At his invitation I visited the University of Alberta. However, while still considering a possible move back to Edmonton by July of 1974, because I had no definite word and indeed very limited communications even as late as March of that year, I decided to break off contacts and resume concentration on my continued clinical and scientific future at Mayo. After notifying Dr. Mackenzie, I and my family readily accomplished this. It was therefore a considerable surprise when Dr. Tim Cameron by then the new Dean, approached me again in October of 1974. The potential target date for my coming to Edmonton was, at that time, July of 1975. As the Faculty's interest in me at this time was significantly more definite, I accepted Dean Cameron's invitation for a return visit to Edmonton in early November of 1974. Relatively soon thereafter, negotiations progressed to the point, that I decided to accept the offer and we did make the move in July of 1975. I am pleased to affirm that I never looked back nor regretted the decision and the move.

ROLE MODELS

If this were my autobiography, I would of course start with the wonderful models and helpers up "life's ladder" I had in my parents as well as in some memorably influential teachers throughout my early education. Later, colleagues and superiors during my war-time

military experiences and my wife Gwendoline E. McGregor, whom I married in 1947, would certainly have a major role. Prudence, and relevance to the topic at hand however, suggest I begin no earlier than the happy experiences I have had with Professor William Rowan in the Department of Zoology during 1946/1947 as I was studying pre-medicine. First as his student, then as his laboratory demonstrator, and later still as his neighbor, (with our houses across an alley from each other), I learned to admire him as a witty, self-deprecating great teacher and scientist and a warm human being. Evidence of his considerable artistry as a draftsman and sculptor remains in the halls of the Department of Zoology, but only personal experiences with him can explain his lasting influence on me, an influence which helped to shape my approaches to academia.

Herbert Rawlinson taught me gross anatomy and also supervised me on a summer research project. He also is well remembered as a great teacher and a good scientist. But above all, he was a true humanist. What I particularly remember him for was his remarkable ability to perceive the essence of any problem and to do so with great rapidity. In my whole life's experience to date, only Ray Keating, about whom more later, could match him in this particular regard. Bert Rawlinson's most remembered advice to me, when he found me fretting about some problems and long-term decisions, was to suggest that I focus first on problems at hand and after solving them consider the long-term without undue anxiety or haste.

John W. Scott, who at one point during my medical undergraduate years, was my Professor of Medicine, and shortly thereafter my Dean as well, certainly left an indelible mark on my life. He was an extraordinarily lucid teacher both at the blackboard and at the

bedside. I have consciously tried to emulate his "hands on" approach and clinical emphasis. I shall never forget his many sound sayings. Among them was the perceptive definition of a good doctor as a perennial medical student. The implication was all too clear—that to be a good doctor one could never abandon one's studies. It was such a pleasure to re-encounter John Scott still active as a clinician upon my return to Edmonton in 1975. Indeed, I could still avail myself of his ever-sound advice. I was delighted when he responded to my request by initiating this series of reminiscences by past Chairmen of the Department of Medicine.

Walter Mackenzie, my Professor of Surgery, was as dynamic and outgoing as John Scott was steady and reflective. He was also a memorable teacher in the school of "hands on" activity, but in many other ways as well. His broad perspective on medicine and surgery, his warm interpersonal manners and his ability to get the best out of all concerned around him, remained an ever-vivid memory for the 23 years I spent away from him until I returned and happily found him still here, just retired as Dean. I have often tried to convey to others, who turned to me for advice, his sound admonition to me on how to get ahead in resident training and beyond. He emphasized the importance of not merely working hard but the equal importance of making it evident that one <u>was</u> working hard. He recommended that if the Chief of a service advised reading up on a subject, it was important to do so promptly and to indicate accomplishment of the task by a brief report. He emphasized the setting of proper priorities, when, upon his advice and recommendation I went to the Mayo Clinic for training. He thought it far more important to give a good account of oneself and to learn all one could, rather than to take in all the cultural benefits

of Minneapolis and St. Paul, (90 miles from Rochester) and the sporting and vacation opportunities in Minnesota with its surrounding states. What Walter Mackenzie accomplished for our Faculty of Medicine by putting it on the world map through his world-wide contacts was evident from my perspective in the south of Minnesota, but became even more impressive upon my return to Edmonton.

Howard H. Hepburn, the Professor of Neurosurgery, taught me as an undergraduate and shared with me much to remember for a lifetime. I was his last intern prior to his clinical retirement. He was without any doubt the best organized human I had ever met. His work habits made me conscious of the importance of good work habits, for a lifetime. (This topic turns up again later in this report). He was the kind of neurosurgeon who could aptly be described as a neurologist who could operate. He dealt with the problems of his chosen subspecialty, by the particular work habit of dealing with each and every patient as completely during each and every encounter as I have ever seen anyone do. When Dr. Hepburn left the operating room or the bedside of a patient, his conscience was completely at rest, knowing that everything that could or should be done for that patient had indeed been seen to. There were many other admirable traits of Dr. Hepburn's that have left lasting impressions on me. Not the least was his unostentatious persistence, alongside his expertise of neurosurgery, to sustain his skills as a general surgeon.

Although this story is meant to be about the Department of Medicine at the University of Alberta I feel that it is relevant to bring in some other major influences on my life, as I trained and subsequently practised, taught and did research at the Mayo institutions. The first and among the longest-lasting influences came from my exposure and

continuing contacts with Randall George Sprague. He was one of my clinical supervisors and later counsellors and colleagues. He was a man of great equanimity as well as of great accomplishments, despite a major health problem. He became a type I insulin-requiring diabetic and had his life saved during a ketoacidotic coma in Chicago, as Professor Rolland Woodyatt had an opportunity to give him one of the first batches of insulin obtained from Frederic Banting. Randall Sprague did not have an easy time with his diabetes. I have personally witnessed his having hypoglycemic episodes and have known about his having had at least one major hyperglycemic episode during a thyroid storm, following his partial thyroidectomy many years later. However, he did live some 70 years on insulin, functioning well as an all-around human being as well as a great clinician and scientist and teacher. I was never his physician, but I understand that he had no significant complications of the diabetes despite the inadvertent imperfections of his diabetic control. Not only was Randall Sprague admirable in what he accomplished in his professional life and how he overcame his health problems, but he was a model to me in his systematic, well-organized approach to solving problems. His approach was that of a journal editor. He spoke well and wrote well and expected others to do likewise. On more than one occasion when I wrote a note to him as a colleague, I would get back not only his written reply but also an edited version of what I had written him. This was never intended nor perceived as a put-down. Those who knew him understood, that it was simply his regular habit to correct his own writing as well as that of others. From another point of view, and with relevance to his great equanimity, when Phillip Hench and Edward Kendall achieved the first (and to this date only) Nobel Prize ever awarded to Mayo staff people, many were of the honest opinion that

perhaps Sprague should have been the recipient rather than Hench. Whether he himself thought so, relevant to the outstanding work he did on clinical aspects of the corticosteroid story, he never let on.

It may seem strange for a reader in the final decade of the twentieth century to have no women listed in the foregoing array. There were indeed few women on the staff of schools of medicine at mid-century. Their number was small even at such a centre as the Mayo Graduate School of Medicine at that time. But even without any consideration of gender, Adelaide Johnson stands out as one of the most outstanding intellectual and creative people I ever encountered before or since I was her student for an all-too-brief period of three months in 1954. She was senior psychiatrist on the staff of the Mayo Clinic. Her background was in psychoanalysis and she was among the most respected figures in American applied psychoanalytic circles. Among her original contributions was the development of an approach whereby a group of psychiatrists individually interviewed all available family members, while the identified psychiatric problem lay with one particular family member. The psychiatrists subsequently got together to compare notes to begin a global and holistic assessment. With this approach, for instance, a problem child was assessed from the point of view of the various family members as well as that of the individual patient. How Dr. Johnson's analytic mind worked, how she communicated with all concerned, but especially how her forceful, direct, but never abrasive approach, often brought to light the true state of affairs, made an unforgettable impression on me.

Almost equally memorable was the way that Dr. Johnson left the staff of the Mayo Clinic some years later. It was apparently upon learning, that despite her status,

accomplishments and seniority—purely on basis of her gender—she was the lowest paid psychiatrist member of the staff, that justifiably outraged Adelaide Johnson. Despite the fact that she was also the wife of Victor Johnson, a distinguished physiologist, who was the overall director of Mayo Foundation, she quit on the spot and took up private practice in the city of Rochester, Minnesota. (All of the Mayo staff members have always been salaried. The staff were discouraged from any discussion of their earnings. It was thus that Dr. Johnson could have worked there as long as she did without knowing the facts, which ultimately led her to leave the Mayo Clinic). Obviously by the late 1950s she imprinted in my mind the importance of gender equality.

I have already referred to F. Raymond Keating who was my clinical supervisor during my Ph.D. studies in the Mayo Graduate School of Medicine and later my section chief in the Division of Endocrinology and Metabolism. Indeed, a man of lucid insights and amazing rapidity in perceptions, he was undoubtedly the best clinical scientist I ever had the opportunity to learn from and work with. I have never forgotten the witty and forthright ways with which he would appear to abhor premature unanimity in a discussion, much as nature would abhor a vacuum. He was very direct, but made it a point not to be offensive. A relevant phrase of his has remained with me: he would say, "I may be wrong, but I do not wish to be misunderstood".

Edward H. Rynearson was a wonderful thoroughly extroverted teacher, colleague and chief of mine. He was such a gifted public speaker, both in medical and lay audience settings, that some, both in the United States and Canada as well as in Britain, regarded him as the "Walter Mitty of American medicine" His humorous, yet profound approach to public

speaking was exemplary. His authoritative reassurance that, on topics of our choosing as clinical or scientific speakers, we are almost bound to be the most knowledgable in that field in any lecture hall or seminar room, I found most helpful both then and in years to follow. Dr. Rynearson was also a favorite of D.R. Wilson and Walter Mackenzie (and vice versa) as a well-justified mutual admiration society.

To Eugene Ackerman, a biophysicist and biomathematician, I owe a tremendous amount in the course of my later scientific development. I benefitted greatly from having him as a co-investigator on some of my NIH-sponsored research projects. I have never met his equal as a mathematical modeller and as a highly detached scientific observer and analyst. An almost mystical talent of the man was his uncanny ability to size up a potential project speedily, but accurately, as to its cost in time and effort. He could anticipate the outline of a future grant application or report from a preliminary discussion. He could not merely indicate the potential pitfalls and complexities of a project, but also predict <u>when</u> his existing schedule would permit him to begin to do something in detail about the tasks relevant to the future research.

Finally, C.F. Code deserves special mention. I encountered Dr. Code first in his capacity of Chairman of Physiology at Mayo. As I was planning to do a Ph.D. in his Department, although with Dr. Alexander Albert as my scientific mentor, Dr. Code insisted, as was his habit, that although he approved of my project, I also had to have an interview with at least two additional members of his staff, who had projects potentially of interest to me. Only so, he insisted, would I arrive at the right decision as to what to do for the coming years of my graduate work. Moreover, I could then ultimately blame only myself if I had

made the wrong choice of project and supervisor.

Later, Dr. Code became Director of Research and Education at Mayo. This allowed me to learn more about the man as a master administrator. I had of course known that he had a brilliant record as a scientist of renown in the field of histamine, its mechanisms and its antagonists with reference to the gastrointestinal tract, as well as in gastrointestinal motility. He had trained with Sir Henry Dale, who had won the Nobel Prize in Physiology. As an administrator, Dr. Code had a world-class overview of the Mayo institutions' advantages as well as shortcomings. He instituted a major extra-mural review committee composed of outstanding scientists and administrators. There was a parallel intramural committee composed of both senior and junior people, and I had the privilege to participate in it. I later learned that this great man had predicted the outcome of the recommendations, both from within and without the institution. In brief, the major administrative reform needed involved setting a Board of Trustees above the existing Board of Governors. As to the educational workings of Mayo, the institution of a Medical School was deemed an essential move to bring Mayo into the proper phase of American medicine and medical education for the last quarter of the twentieth century. When all this was revealed and some of it instituted, the staff of the Mayo Clinic in a referendum, unequivocally voted down the proposal to have a medical school. Mayo physicians, perhaps justifiably, quibbled at the potential cost and perhaps less reasonably feared, that undergraduate medical students would come between themselves and their patients. It is a testimony to Dr. Code's broadness of vision and administrative skills, that plans to cope with the financial aspects were readily evolved. In addition to some federal and state

governmental help, a fund-raising program was instituted. A promise was made, and later kept, that 100 million dollars would have to be pledged before the school could be started. However, it was Dr. Code's virtually Machiavellian abilities, which ultimately brought the Mayo staff later to accept the Mayo Medical School concept. He approached and persuaded the "ring leaders" of the opposition among the Mayo staff to become the implementation committee for the medical school.

Dr. Code, himself originally a Canadian, lives in retirement in California and has visited the University of Alberta on more than one occasion. I learned from him the need to plan carefully, to be creative in achieving consensus and to lead skilfully in the face of major academic institutional challenges.

HISTORY OF THE DEPARTMENT

PRIOR TO 1975

The University of Alberta's School of Medicine, under the Faculty of Arts and Sciences was organized in 1913 as a three-year school; at the end of the three year course in medicine students were accepted for the final two years at McGill University or the University of Toronto. The class of 1925 was the first to receive their medical diplomas in Edmonton, the University of Alberta having begun to offer the entire medical curriculum.

Dr. Heber C. Jamieson was the first appointment in Medicine as Lecturer in 1920. The medical building was completed in 1922. In 1923 three clinical professorships were established, one of which, in Medicine, was filled by Dr. Egerton L. Pope. He was the Head

of the newly-formed Department of Medicine. The staff were all part-time teachers. Initially, Pediatrics, Psychiatry and Preventive Medicine all existed under the Department of Medicine for administrative purposes, and it was only in the early 1950's that they were established as separate departments.

Dr. Pope remained Head until his retirement in 1944. Dr. John W. Scott succeeded him as Professor of Medicine. In turn, Dr. Scott became Dean of the Faculty of Medicine in 1948. However, Dr. Scott continued as Head of the Department of Medicine, as well as Dean of Medicine. Only in 1954 did Dr. D.R. Wilson succeed him as Department Head.

Even in 1954, the entire clinical teaching effort was done by part-time staff. In that year, Dr. D.R. Wilson, along with Dr. Robert S. Fraser, became the first Geographic Full-time (GFT) members of the teaching staff.

It was in 1957 that the GFT concept spread to include pediatrics, psychiatry, clinical laboratories and rehabilitation medicine. In that year some teaching clinics were also organized in the out-patient department. By 1959 there was an outpatient department in the University Hospital itself; previously it had been in a downtown building.

Although it was at the end of World War II that the program of Postgraduate Training in Internal Medicine was set up, it was not until 1956 that the University of Alberta Hospital was accredited by the Royal College of Physicians and Surgeons of Canada for teaching of post-graduate students. It was also the last year in which other individual City hospitals were approved for post-graduate training. From that point on, university programs as a whole were approved by the Royal College, and this approval or non-approval embraced the total network of teaching hospitals.

From then on, the Department of Medicine usually had at least one graduate student pursuing clinical research toward a Master of Science degree. However, it was not until 1959 that, in the field of postgraduate training, formalized programs were developed.

Nineteen hundred and sixty-nine was the last year that Dr. D.R. Wilson was Chairman of the Department of Medicine; during that year the Department's administration and staff moved from the University of Alberta Hospital to the new Clinical Sciences Building. From 1969-1974, Dr. R.S. Fraser was Chairman. Subsequently, while Dr. R.S. Fraser went on sabbatical leave, from July 1974 through June 1975, Dr. B.J. Sproule was Acting Chairman. In mid-1975 I took over the Department.

In 1962, the Department of Medicine was begun to be reorganized into a number of divisions, each operating within the geographic confines of their own respective wards at the University of Alberta Hospital. During the first year of Dr. R.S. Fraser's Chairmanship in 1969, further divisionalization of the whole Department occurred. These divisions were: Cardiology, Endocrinology and Metabolism, Gastroenterology, General Internal Medicine, Hematology, Infectious Diseases, Nephrology, Neurology, Pulmonary Medicine and Rheumatology. Subsequently a Division of Dermatology was added and Oncology was recognized as a part of Hematology.

DEVELOPMENTS 1975-1986

In 1975 Medical Oncology was recognized as a Division with its base at the W. W. Cross Cancer Institute. Hematology continued as the Division of Clinical Hematology. In the same year, formal clinical teaching units were introduced on Stations 31 and 32 of the

University of Alberta Hospital and in the Royal Alexandra Hospital. This was a major step forward in providing planned, concentrated clinical teaching with graduated responsibility increasing from the student intern to the senior resident. It also helped meet the requirements of the Royal College of Physicians and Surgeons with regard to the training of medical residents.

Formal monthly meetings with the Chiefs of Medicine at affiliated teaching hospitals and with Divisional Directors were started in 1975, as well as a monthly Departmental research meeting. An academic administrative re-organization of the Department was initiated with standing committees for education, clinical practice and research. The chairmen of these committees, with the Departmental Chairman and the Administrative Officer, formed an Executive Committee. A Long Term Planning Committee was also established under the chairmanship of Dr. J. B. Dossetor: it included full- and part-time staff from the University Hospital and the Affiliated Teaching Hospitals.

Still in 1975, the status of the part-time staff was reviewed. This review resulted in the identification of excellent teachers who devoted a major portion of their time to scheduled teaching. These were recognized as major part-time teachers who were proposed for, and received, somewhat improved compensation.

It was also during 1975 that the University of Alberta Hospitals' Department of Physical Medicine and Rehabilitation, headed by Dr. Clyde Nicholson, joined the Department of Medicine as its 13th division.

Further efforts to create better defined and improved conditions for the full-time and part-time staffs included the establishment of new Departmental policies for the acquisition

of new staff, namely through search and selection committees, and for the promotion of the part-time staff. On the basis of the latter, every part-time staff member was considered for promotion at three to five year intervals, with defined criteria, and with the involvement of divisional directors and chiefs of medicine at the Affiliated Teaching Hospitals advising the Department Chairman.

During 1977, the weakness in the teaching of basic clinical skills to medical undergraduates gained recognition. This assessment was carried forward to the Faculty Curriculum Advisory Committee as well as to the Dean and as a consequence, a Faculty clinical skills coordinator in the person of Dr. J.A.L. Gilbert was appointed to improve this aspect of clinical teaching.

It was in 1977 also that the first Chief Medical Resident was appointed after a hiatus of nearly a decade. During six to 12-month terms, excellent senior residents helped to coordinate resident training and functioned usefully within the educational pyramid.

In that year, the Clinical Teaching Units (CTU) were improved through some physical alterations, and the program of "Principal Teaching Physicians" (PTP) was instituted to coordinate and intensify the clinical learning experience for student interns and residents. Instead of the multiple specialty or sub-specialty participants on each CTU a single PTP was in charge for a month. To improve the out-patient learning experience of residents, full-time assignment of two residents, for two months at a time, to the Health Sciences Clinic was begun. These residents, under the personal supervision of the Department Chairman, attended the general internal medicine and selected sub-specialty clinics and shared in the night duty roster in the Emergency Department.

In 1977 a trial of a Clinical Teaching Unit at the Charles Camsell Hospital turned out to be a success. But a similar trial at the Edmonton General Hospital could not continue because we could not supply a sufficient number of residents for the unit. The latter development was certainly not the fault of the excellent teaching staff at the EGH, who maintained the most popular teaching environment among students and residents at their hospital.

During 1977 Dr. R.H. Wensel was appointed Departmental Coordinator for planning of the new Health Sciences Centre. A significant, nearly ten-year commitment of the Department to the planning of the Health Sciences Centre was thus under way.

A highlight of 1977 was a report of the Department's Long Range Planning Committee. Recommendations were made with regard to the composition of the Department, its divisional structure, the relationship with other departments and hospitals, approaches to finances, teaching, research and patient care. This report described the Department's goals, and aspirations as well.

On the basis of the Long Range Planning Committee's report, three additional studies were undertaken. These were in relation to 1) future space and staff needs; 2) research activities as a basis for specific research planning; and, 3) optimal approaches for further improving the teaching of clinical skills.

Another assessment by the Department's Long Range Planning Committee concluded in 1977, that two to three new full-time staff would be required in each of the next two years and that, from 1980-85 approximately five additional staff would be needed each year. It was stated in that year's Annual Report that "it may be necessary to begin moving some of

the divisions to a base outside the University of Alberta Hospital to accommodate the necessary new personnel".

In 1978, the divisional directors in concert with members of each division identified their needs and prepared their plans through 1985. The Department's Executive Committee reviewed the composite plans and these were submitted to the Dean. Both the number of the staff and their potential future locations for academic functions were defined in this report. Serious office and laboratory space shortages were identified and some improvements were recommended through the creation of some laboratories in existing teaching space.

In 1978, Dr. J.S. Percy succeeded Dr. Wensel as Department Coordinator for Health Sciences Centre planning. In that year, Dr. D.R. Wilson retired. It was during 1978 also that the staff of the Royal Alexandra Hospital (RAH), numbering 22 members, expressed the wish to discontinue undergraduate clinical teaching unless they could have a larger number of residents. One approach to the solution of this dispute was to seize the opportunity to "shorten" the department's over-extended affiliated teaching hospital "perimeter", and to exclude the RAH from the Department's affiliated teaching hospital network. However, this solution was not accepted by the board of Governors of the Royal Alexandra Hospital. The resulting compromise brought about an improved set of medical student and resident teaching arrangements at the RAH.

The overall plan of the Department for its affiliated teaching hospitals was made explicit in 1978, namely that it needed a larger number of full-time teaching and research staff appropriately supported at each affiliated hospital to staff, evaluate and administer the

teaching programs. It was also recommended that some of the affiliated hospitals should concentrate on family practice residents, some others on second year postgraduate internship, instead of all of the affiliated hospitals competing for a rather limited number of Royal College resident trainees in internal Medicine and the sub-specialties. (See also section on the Department and the UAH and the ATH's).

In 1978, as during my predecessor's tme, further attempts were also made to try to establish a Departmental (group) practice plan. The basis for the recommendation submitted to the Faculty Committee on Professional Activities was that the two divisional practice plans in Immunology-Nephrology and in the Pulmonary divisions, along with other divisional plans, be Departmentally coordinated. The guidelines were to ensure that further divisional plans throughout the Department:

1. Be compatible with University regulations.
2. Be compatible with faculty, departmental and divisional goals, and
3. Be reasonably homogeneous while allowing for divisional differences relevant to particular sub-specialty practices.

The overall goal of a department-wide network of divisional plans was to generate sufficient, dependable, long-term funding to contribute significantly to the enlargement of the full-time academic staff and thereby to the Department's development. Unfortunately, this proposal for a departmentally coordinated network of group practice plans was set aside (and was not pursued) at the faculty level.

Also in 1978, because of its size and administrative complexity, the Department (in both University and Hospital roles) created the position of a Vice-Chairman to which Dr.

B.J. Sproule was appointed.

In 1979, the Division of Physical Medicine and Rehabilitation separated from the Department of Medicine to become a free-standing Faculty division.

Another Departmental Long Range Planning Committee got underway in 1979 under the direction of Dr. J.S. Percy. One of its major accomplishments was the "pod" concept for both the University Hospitals and the affiliated teaching hospitals. This was implemented in July 1981: 1) to ensure that pyramidal organization and teaching—from student interns through junior and senior residents occurred; 2) to correct the inadequacy of the Phase III teaching program, whereby one-third of the third and fourth year medical students did not have an opportunity to be taught medicine at the University of Alberta Hospitals; 3) to bring under control the admission of "undesignated" emergency patients at the University Hospitals; and 4) to provide an in-depth (and on-going) assessment of the Department's need for teachers and teaching beds. (See also later: ISSUES AND CONCERNS, TEACHING).

In 1979 after a Hospital Accreditation review, the Medical Staff Advisory Board recommended to its governing Board the exclusion of the UAH from rotating internships.

After previous similar reviews, as well as during this evaluation, the Department of Medicine was praised for its educational performance in training the first year rotating (graduate) interns. However the educational opportunities in Obstetrics and Gynecology and Pediatrics continued to be so limited as to force the termination of the assignment of rotating interns to the UAH.

Some departmental staff welcomed this change, claiming that the presence of

graduate interns led to confusion on the teaching units between these graduate physicians and the student interns (third and fourth year medical students). These claims were, in my opinion, ever smaller semantic problems as we continued to define the roles of the two categories of interns. Moreover there was no educational basis or justification for differentiating between first year residents and rotating (first year) interns.

In the long term moreover, the irretrievable loss of these graduate doctors in training was felt, and continues to be felt, as the resident manpower became progressively more restricted. This previously welcome "cushion" of postgraduate trainees was lost to the UAH staff and to the patients. The realization came belatedly that the rotating interns' benefits from training at the UAH were also never quite replaced, despite the excellence of continuing educational efforts on their behalf at the ATH's.

During 1980, the fifth anniversary of the appointment of most divisional directors, guidelines, criteria, and procedures for their review and possible reappointment every five years were developed, agreed upon, and subsequently approved by both the University and the University Hospitals. This was an extension of the policy begun in 1975 to systematize the operations of the Department. The reviews took place during 1981 with all directors being reappointed (see Appendix of Divisional Directors concerning changes since 1975).

In 1981, the Department Chairman with some members of the Department of Medicine, in concert with others from within and without the Faculty of Medicine, were responsible for helping to procure a 1.2 million dollar endowment from the Muttart foundation for the Muttart Diabetes Research and Training Centre (DRTC), to which the Department Chairman was appointed Director. A major equipment grant of $103,569

helped to establish the Centre's Core laboratories. This accomplishment reflected the generally steady increase in Department research activity since the late 1970's, an increase which has continued as evidenced by greater research funding each year and more full-time (and nearly full-time) researchers being added to the staff. (See also a further note on the DRTC).

More permanent arrangements for on-going long-range planning in the Department were established in 1981 so that long-range planning became an essential function of the existing standing committees of Education, Research, Clinical Practice, and of the Council of the Chiefs of the Affiliated Teaching Hospitals.

During the 1980's, the Department's Resident Academic Advisory Group (now the Resident Training Committee), under the guidance of Dr. A.M. Edwards, made great strides in improving the resident training program. A resident Academic Travel Fund of $16,000 per year was established from the Department's Excess Earnings Trust Fund to allow residents to attend educational meetings. The rotation schedule was simplified to multiples of one month blocks, standards of training were improved, applications were more carefully screened, and promotions were given with more circumspection. The shortage of resident positions continued to be a problem, as evidenced by the demise of the ambulatory care block rotation, which now had to be integrated into the rotations on the General Internal Medicine pods at the University of Alberta Hospitals. Regrettably, this was the end of a serious attempt at emphasizing resident education in a setting in which outpatient care was the first priority.

In 1980, the Alberta Heritage Foundation for Medical Research (AHFMR) began to have an effect on the Department. The availability of AHFMR fellowships and

studentships contributed to a dramatic rise in the number of graduate students, and researchers were able to begin to replace outdated equipment. In 1981, AHFMR establishment grants helped new GFT staff begin their research careers more effectively and without the previously experienced delays. In 1982, the first two AHFMR scholars, Dr. W.C. Leung and Dr. M. Dasgupta joined the Department.

Phase I of the new Walter Mackenzie Health Sciences Centre was completed in 1981 and two Department of Medicine divisions, Rheumatology and Immunology-Nephrology moved their beds to the Centre. The offices of Cardiology moved to the Centre within the year and the rest of the Department in 1986.

In 1982, the task of redefining the various categories of full-time staff was accomplished for the purposes of: a) giving recognition, especially in the categories equivalent to full-time appointments at the University, but where no University full-time salary is paid; b) defining the meaning of each full-time category; and c) stating explicitly the limits (of the extent) to which the University can recognize and reward full-time staff whose salary is provided by extramural or hospital funding sources. At the same time, the process of differentiating rank titles was concluded. For example, "associate research professor" denoting an academic with a job description involving primarily research, "associate professor of internal medicine"—where the main functions are teaching and clinical practice, and the regular (full time) rank of "associate professor" (teaching, research, clinical practice: all three).

In 1982, a Departmental Council was formed according to new University regulations; terms of reference were drawn up and approved both for membership and for the council's

functions. The May and October 1983 departmental meetings were the first two in the format of Departmental Council meetings. At the May Departmental Council meeting, the new full-time categories were approved with individuals in these categories having agreed to their categorization prior to that meeting. At the October meeting, a policy for the regular review of committee memberships by Departmental Council was approved. One-third of each committee was to be elected or re-elected each year.

During the years 1982 and 1983, the Department Chairman was President of the Canadian Association of Professors of Medicine. In the fall of 1983, following the Royal College meetings in Calgary, the association had a highly successful meeting in Banff. That meeting was (as were all of the twice-yearly get-togethers of the Chairmen and their associates of the sixteen Canadian departments of medicine) both academically rewarding and of significant practical use. Throughout the eleven years of the Chairman's participation in the association, all Canadian departments of medicine experienced problems of considerable similarity. Sharing these problems and examining them were helpful. Moreover, in many instances practical solutions for these problems were evolved. These solutions were of relevance not only to the respective universities and affiliated hospitals, but to relationships to professional organizations as well, and especially to the Royal College.

For 1983 the Department's self-study for the President's Advisory Committee on Campus Reviews (PACCR) was the predominant administrative effort. In a sense, the entire department was involved, but the major burdens fell on the administrative staff, the standing committees, the divisional directors and the chiefs of medicine at the affiliated

teaching hospitals.

The Department's Self-Study was completed and submitted in February 1984. The Department's organization chart from that Self-Study Report is shown in Figure 1. The onsite visit by the Unit Review Committee, composed of distinguished extra- and intra-mural members occurred 16-19 April. The PACCR Report was received and a formal response to it was made by collating the responses of Divisional Directors, Chiefs of Medicine, Standing Committees and individual staff members. The PACCR Report contained useful recommendations, some of which had already been implemented. Others were implemented later.

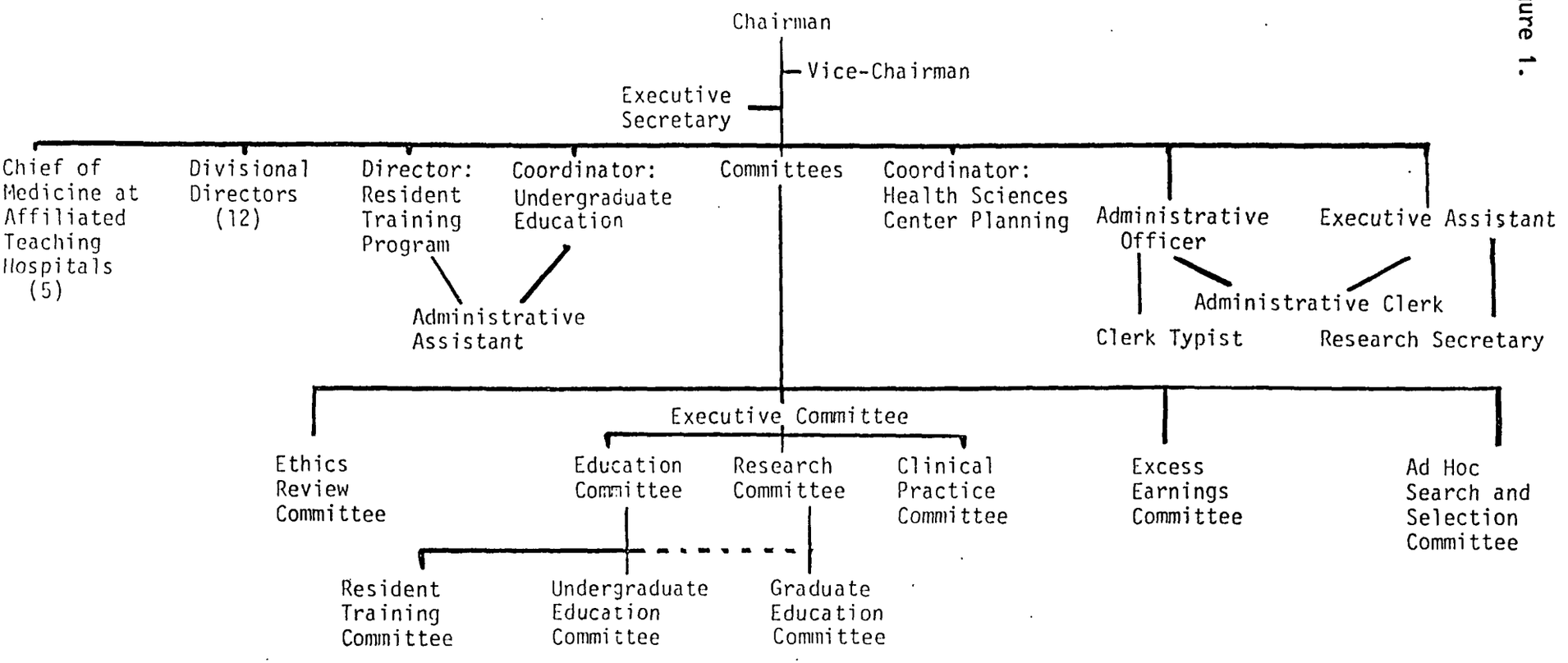
Administrative reorganization arose from our Self-Study, the PACCR Report and the review of the department chairmanship which took place in the early autumn of 1984. The essence of the reorganization was to make the Department's administration more direct and effective. Some of the details were: elimination of the Executive Committee; direct reporting by each standing committee chairman to the Department Chairman; expansion of the role of the Vice-Chairman; and enhancement of administrative communication by a weekly meeting of the Department Chairman, the Vice-Chairman, the Administrative Officer and the Executive Assistant as an administrative committee.

In response to the University Hospital's Accreditation Survey, monthly meetings of the UAH Department of Medicine staff were instituted in April of 1984; three of these were to coincide with Department Council meetings. The number of meetings held with the Chiefs of Medicine at Affiliated Teaching Hospitals was reduced to one every other month.

The following positions were created: Associate Director (Subspecialties) of Resident

UNIVERSITY OF ALBERTA - DEPARTMENT OF MEDICINE

ORGANIZATION CHART



Administrative Support: Executive Assistant

Administrative Support: Administrative Officer

January 1984

Figure 1.

Training (Dr. A.R. Turner) to assist the Director; Graduate Education Coordinator (Dr. S.F.P. Man) to chair the new Graduate Education Committee, and Undergraduate Education Coordinator (Dr. R.A. Ulan) to chair the Undergraduate Education Committee.

At the Department Council meeting in June, the following were elected:

Research Committee:	Dr. J.B. Dossetor (*end of term* 1987)
	Dr. A.B.R. Thomson (1987)
Ethics Committee:	Dr. A.S. Russell (1987)
	Dr. G.C. Man (1987)
Clinical Practice Committee:	Dr. R.F. Taylor (1985)
	Dr. F.A. Herbert (1987)
	Dr. P. Davis (1987)

Concern was expressed over the Departmental Ethics Committee having to deal with an excess of experimental protocols for human investigations in departments other than Medicine. While continuing the helpful attitude of the Department to smaller academic units on and off campus, efforts were made to limit the Ethics Committee's activities to on-campus, Departmental protocols. A Deputy Chairman was appointed in the person of Dr. P.M. Venner.

Program plans for five and ten years beyond 1984 were solicited and received from the Divisional Directors. A research retreat and a sequel to it were held to deal with recruiting of researchers. Recruiting as a topic was made a permanent agenda item of the meetings of Divisional Directors and of the UAH Department of Medicine.

The Department's concerns about the move to the Walter Mackenzie Centre

regarding space, chart control and storage, operation of clinics, supplies for clinics, off-hour access for university personnel, mail distribution, and mediation of University—University Hospitals disputes were reported to the Faculty and University Hospitals administrations.

Dr. B.J. Sproule recommended that someone else be appointed to the position of Vice-Chairman, which was agreed to have a significantly expanded role, as of January, 1985. He had most ably served as Vice-Chairman from January 1, 1981 to December 31, 1984. Dr. R.F. Taylor was selected as his successor.

The job description of ward chiefs was expanded and regular meetings for them were instituted to ensure a greater role and more authority for ward chiefs.

1985 was the first year in which admissions and length of stay annual statistics were made available to the Department by the UAH; statistics from previous years had to be built up from monthly statistics. This new approach may explain partially the jump from 6,205 admissions in 1984 to 7,462 admissions in 1985; since 1982 the maximum fluctuation in yearly admissions was 400. Mean length of stay for Department of Medicine in-patients in 1985 was 13 nights. The major contributor to this figure was Nephrology (mean length of stay of 31.9 nights) reinforcing the notion that the University Hospitals and Government needed to act on the problems of the over-burdened Nephrology service. Visits to the Medicine Clinics remained relatively stable at 13,036 for 1985 (12,809 for 1984).

In 1986, plans were developed to begin clinical oral examinations at the end of the Phase III Medicine rotations. The format was to be the Objective Structural Clinical Evaluation (OSCE) to be given three to four times per year so that each student would be examined relatively near the end of his/her medical rotation or soon afterward. Efforts

were also begun to develop a more extensive set of educational objectives for Phase III Medicine.

The loss of two resident positions in 1985 necessitated the reduction in the number of junior residents at the UAH. Problems with patient care and teaching resulted from this move especially on the General Medicine wards.

The Royal College approved training programs in Clinical Hematology and in Endocrinology and Metabolism based on excellent applications.

The impact of the AHFMR continued to be felt as more scholars, fellows, and students joined the Department. AHFMR Scholarships were awarded to Dr. M. King in Pulmonary Medicine and Dr. F.X. Witkowski in Cardiology, bringing the total number of scholars to nine. Research funding rose by 16.8% to $6,532,615. Papers published rose from 159 in 1984 to 199 in 1985; published abstracts from 194 to 200.

The Alberta Heritage Foundation for Medical Research remained the single largest contributor to Department research funding at $2,647,729 for 1985, up marginally from 1984. The Alberta Cancer Board was up substantially to $924,608 from $602,650 in 1984-85. The Medical Research Council of Canada was the third highest provider at $635,714, up 2.8% over 1984-85. It was gratifying to the Department to see a 216% increase in the support of research from the Special Services and Research Committee of the University of Alberta Hospitals. In 1985-86, the SSRC provided $331,687 as compared with $104,995 in 1984-85.

The move to the W.C. Mackenzie Health Sciences Centre (WMC) was completed in 1986. Total number of beds in the Department was reduced by the move to the WMC and then reduced further by budget-induced bed closures and then even more by the need

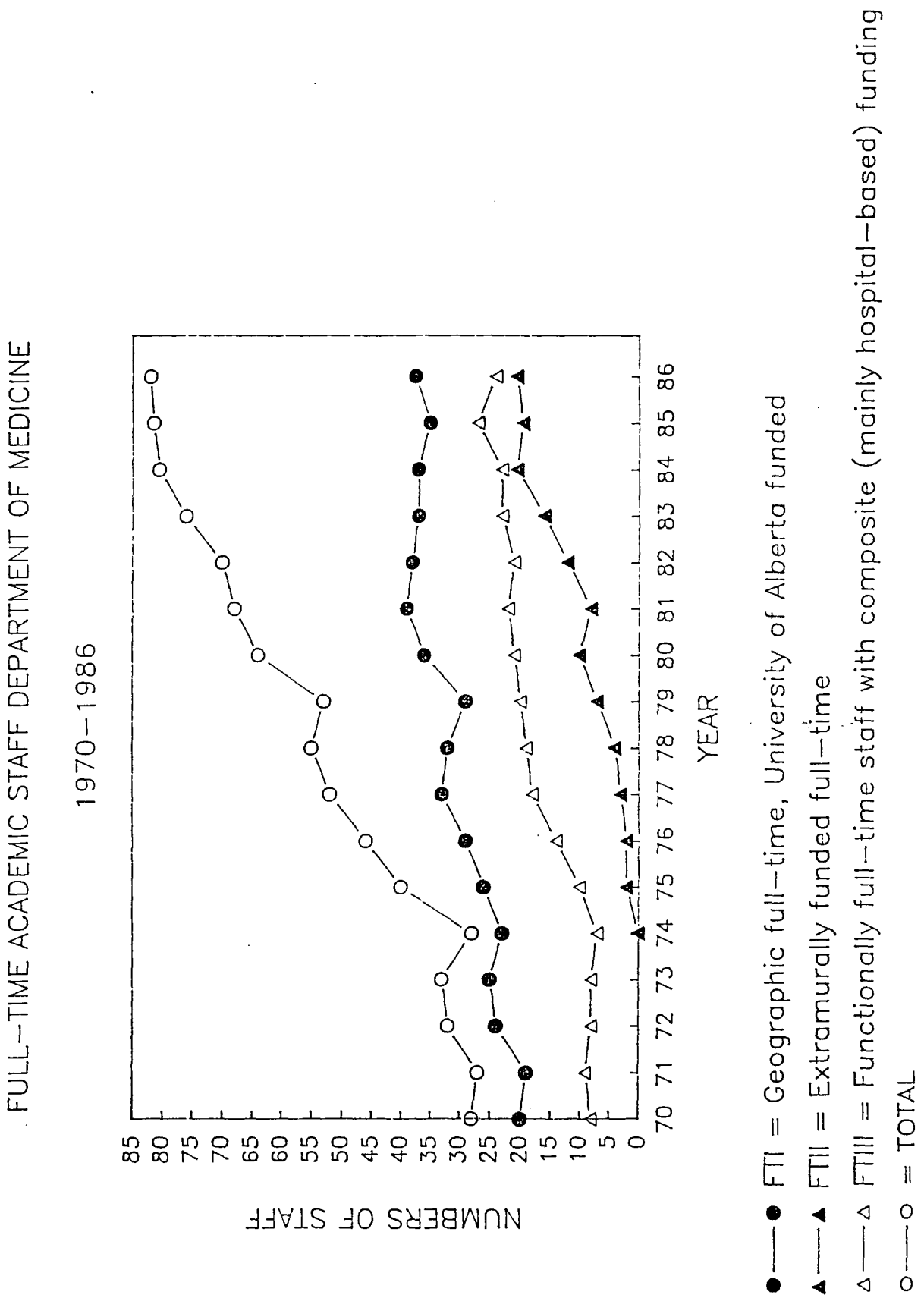
to provide increased numbers of beds for Cardiovascular Surgery. The number of beds available to the Department was 229 which was considered to be marginal for the effective operation of a tertiary referral service in a large University Hospital.

Total research funding coming into the Department reached in excess of $7 million for 1986, a 10.8% increase over 1985. Members of the Department continued their scholarly affairs with the production of 259 papers, 239 abstracts, 32 book chapters, 2 letter to-editors, and 2 books in 1986. While these statistics encompass the whole department, virtually all of the output was from the UAH Department of Medicine.

The Department of Medicine was by this time the largest department (in terms of numbers of professional members) in the University Hospital, in the Faculty, and indeed in the University of Alberta, with a total of 82 full-time members and 79 part-time members (City-wide). Of these totals, 56 GFT's and 12 PT's were at the UAH. The growth of the departmental full-time academic staff is shown in Figure 2. The part-time staff numbers, along with the location of the entire staff by hospitals (comparing 1977 and 1986) are in Table 3.

As of July 1986 the AHFMR supported components of the Department numbered 11 Scholars and three Clinical Investigators. There were also eight Research Fellows, five Clinical Fellows, nine students and seven Summer Students all supported by AHFMR. The Departments' total of Graduate Students, exclusive of medical residents, was 22. Of these five completed advanced degrees within 1986.

Figure 2.


FULL-TIME ACADEMIC STAFF DEPARTMENT OF MEDICINE
1970-1986
NUMBERS OF STAFF
YEAR
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0
70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86
● FTI = Geographic full-time, University of Alberta funded
▲ FTII = Extramurally funded full-time
△ FTIII = Functionally full-time staff with composite (mainly hospital-based) funding
O = TOTAL

ISSUES AND CONCERNS

ADMINISTRATION

1. Interrelationships of the Department of Medicine with the University of Alberta Hospitals and the Affiliated Teaching Hospitals.

This topic had been well reviewed by the Department's Long Range Planning Committee, which rendered it's report in September of 1977. Because the essentials of the differences and similarities among the constituent hospitals were so well outlined in three tables of that report, those tables are appended here (Tables 1-3). The first one compares and contrasts teaching, research and patient care functions by the staff of the University of Alberta Hospitals (UAH) including the Cross Cancer Institute and the staff of the other Affiliated Teaching Hospitals (ATH). The differences as well as some similarities are self evident. The data are relevant to changes which occurred in the succeeding nine years and warrant the following comments.

In phase III teaching in 1977, clinical teaching units (CTU) were established successfully at the Royal Alexandra Hospital (RAH), the Charles Camsell Hospital (CCH) and the Misericordia Hospital (MH) but with only transient success at the Edmonton General Hospital (EGH).

Royal College Specialty Training Program involvement became more formal and related mainly to the clinical teaching unit as and when these were developed at the ATHs.

Concerning research in a formal and extramurally funded way, only minor changes occurred, for instance in Cardiology at the Royal Alexandra Hospital.

TABLE 1. TEACHING, RESEARCH AND PRACTICE WITHIN THE DEPARTMENT OF MEDICINE IN 1977

		Staff of UAH (WWCCI included)	Staff of Affiliated Hospitals
TEACHING	Phase II	Heavy commitment.	Almost no commitment.
	Phase III teaching	Heavy commitment through CTU's and specialty electives.	No formal CTU commitment, but heavy commitment to student interns at RAH, EGH and MH.
	Province of Alberta, 2 year pre-registration internship	Minor involvement.	Heavy commitment.
	Family Practice Program	Not involved, except in Out-patient Clinics at WWCCI.	Heavy commitment
	Royal College Specialty	Heavy commitment.	Minor commitment; may become more involved with residents in 3rd year of Internal Medicine RCPS(C) Program as this evolves.
RESEARCH	Research	Each division responsible for development of research; some divisions too small for a 'critical mass' to promote and foster research.	Very little involvement.
PATIENT CARE	Inpatient Practice	1) Specialty IIIry Care Programs; 2) Subspecialty Services; 3) Clinical Teaching Units; 4) General Internal Medicine Service	Large family physician and general internist component in care of medical patients. Few special IIIry care programs; some special management ambulatory care programs. Medical subspecialists are not widely divisionalized.
	Outpatient or Ambulatory Care	Half in CSB or subspecialty Clinics; half in private offices of MD internists.	Virtually all carried out in private offices.

As to in-patient practice, medical subspecialists became progressively divisionalized as indicated in the chapter on the Department's history, as well as in the records of the appointments to the staff year by year (Appendix I).

Ambulatory care remained essentially as described, both at the UAH and the ATHs. The Long Range Planning Report pointed out, that an excessive amount of patient care was carried out in the Clinical Sciences Building (CSB) at the UAH, unrelated to teaching or without students at any level being present. The causes of this were relevant to *i)* the geography of the CSB, *ii)* the absence of a departmental practice plan, *iii)* the pressures particularly on subspecialists (mostly unavailable at the affiliated teaching hospitals), *iv)* the Department's inability to supervise the building adequately, *v)* a dearth of subspecialty clinics in existence (exceptions functioned all along, of course, for instance in Endocrinology and Metabolism). The situation changed fundamentally in the autumn of 1986 when the Department was moved into the Walter Mackenzie Health Sciences Centre. Away from the Clinical Sciences Building, it had multiple clinics established. In the ensuing years the Departmental Practice Plan came into operation solving some of the problems with regard to outpatient care and associated teaching.

Another well-described set of observations prepared by the Long Range Planning Committee in September of 1977 compared the administrative and organizational structure in the teaching hospitals (Table 2). Little comment is needed concerning any major changes until 1986 and beyond. Regrettably, the staffs of the affiliated teaching hospitals were mainly responsible for resisting changes in the attempts at increased academic functions in their hospitals, *i)* through clinical teaching units but especially *ii)* through an increase of

Table 2. ADMINISTRATIVE AND ORGANIZATIONAL STRUCTURE IN EDMONTON TEACHING HOSPITALS IN 1977

	UAH*	WWCCI** and CCH***	Affiliated Teaching Hospitals†
Chief of Department	University Department Chairman has always been Chief of Hospital Department. He, thus, functions as a focal point in research, divisional subspecialty needs and teaching commitments for those in the department even if Faculty is responsible for Phase I, II and III curricula.	WWCCI Chief of Medicine is joint appointee of U/A & Prov. Cancer Hospitals Board. CCH Chief is joint appointee of U/A & Federal Dept. Nat. Health & Welfare. Both are responsible for patient care and teaching (student interns) in these hospitals.	Chiefs of Departments are selected by members of each department, or by the respective Hospital Board, formerly for yearly terms, now for 3 year terms, the choice "to be acceptable" to the University. Main responsibility for teaching (at RAH) is invested in a GFT University appointee whose purview is limited to this area.
Governing Board	Boards have full control of each hospital with final authority in respect to all matters pertaining to the operation of the hospital.	The WWCCI is governed by the Provincial Cancer Hospital Board who agree to the Dean being on all selection committees.	There is no requirement for the Board to accommodate university plans, or academic aspirations except that Faculty is represented on the board and that hospital appointments are made either after mutual agreement (PT members of Dept. of Medicine U/A)) or on Faculty recommendation (GFT, Dept. of Medicine, U/A).
Medical Advisory Board or Committee	The Boards include executive and elected representatives of the medical staffs. The medical staffs are responsible ultimately to the Governing Board for clinical and scientific work of the hospital, reviewing professional practice, improvement in patient care, etc. Most of these aspects do not relate to teaching or research or other primarily academic (or University) functions.		
Staff Appointments within Department of Medicine	All appointments are jointly made by hospital and university, with University Divisional research considerations usually having priority except, when certain departmental (UAH) patient care programs dictate a service need that must be met. In General Internal Medicine, appointments are principally of MPT type.	At WWC appointments of full-time and scientific staff only after mutual agreement between Faculty and the Board. There is also a joint liaison committee and a joint appointed FT as head of the Division of Oncology (U/A). For CCH, all FT appointments are made jointly by Faculty and Hospital.	Appointments are made on the basis of clinical (patient care) need, and on individual basis. There is no obligation to consider University teaching or research needs. Even with a subspecialist, prior opinion is not necessarily obtained from the University Divisional Chiefs. There is no divisionalization at affiliated hospitals. Most internists are in the Division of General Internal Medicine though some also have joint appointments in departmental (U/A) subspecialty divisions.

* Under the University of Alberta Hospital Act
** Under the Cancer Treatment and Prevention Act
*** Under Health and Welfare, Canada
† Operating under the Alberta Hospitals Act.

the full-time academic staff members located geographically in their hospitals—so the popularly elected (rather than academically selected) Chiefs persisted. Unfortunately with this system, little progress in intensified academic activities was possible, especially in the extra-murally funded and peer-reviewed research sphere. There were of course notable exceptions. Attempts were made for instance, with some success at the Royal Alexandra Hospital in Cardiology. Regrettably, as attitudes gradually changed, opportunities for University full-time funded staff positions became unavailable. (History repeated itself here. The previous story [1972] was well described in Dr. Fraser's report). Nevertheless, some full-time positions on hospital-based funding in Intensive Care and Coronary Care became possible and were established (see the chapter on the Department's history). Beyond the time of my chairmanship, the Practice Plan also brought some improvement in the full-time staff situation at the ATHs.

A further outcome of the Long Range Planning report described the composition of the Department of Medicine in those early years of my chairmanship (Table 3). For contrast, I have superimposed the staffing situation as it stood in mid-1986. The changes shown have relevance to the foregoing comments, as well as to the history of the Department during 1976-1986.

2. The Department of Medicine in Its Relationship with the University of Alberta Hospitals and It's Administration.

a) Funding of Staff and Activities

The lack of designated budgeted funding for medical education had been the

Table 3. COMPOSITION AND LOCATION OF STAFF DEPARTMENT OF MEDICINE

		1976-77 *(1985-86)*						
Type of University Appointment	U.A.H.	W.W.C.C.I.	R.A.H.	E.G.H.	M.H.	C.C.H.	U.ofA. ONLY	TOTAL
A. Full-Time Members F.T.I.: 1. Geographic Full-Time (G.F.T.)	29*(29)*	3*(3)*	1*(2)*			1	*(2.5)*	34*(37.5)*
2. Full-Time (F.T.-II & III)*	12*(27)*	3*(7)*	*(3)*	*(2)*	*(1)*		3*(4.5)*	18*(44.5)*
B. Part-Time Members	17*(12)*	*(1)*	17*(27)*	10*(11)*	9*(18)*	4*(7)*	*(3)*	45*(79)*
C. Visiting Staff Members	2*(0)*							2*(0)*
D. Cross Appointments and Honorary	11*(8)*	*(1)*	1*(0)*	1*(2)*		1*(0)*	*(2)*	14*(13)*
E. Emeritus							2*(7)*	2*(7)*
F. Administrative Professional Officers (APO)							2*(2)*	2*(2)*
TOTAL	71*(76)*	6*(12)*	21*(32)*	11*(15)*	9*(19)*	6*(8)*	5*(21)*	129 (183)

* Externally funded: F.T.II—through the University of Alberta; F.T.III—through the "external" funding institution.

continuing source of problems, not just for the Department of Medicine, but for the entire medical school. With regard to the University Hospital (UAH), the focus of course is on clinical education in a hospital setting. It can safely be stated that neither the Advanced Education nor the Hospitals and Medical Care departments of the Alberta Government covered the clinical education costs either in the University or in the University Hospital budgets. This situation of course, left the Faculty of Medicine, the Department of Medicine and other department's as well as the University Hospitals itself, scrambling to look after salaries and other costs involved in clinical education. Essentially, the traditional approach of expecting the volunteer teachers (virtually unpaid) to be teaching, in the process of caring for their patients, prevailed. In the case of University-salaried and hospital-salaried clinical teaching staffs, the salaries were thought to be for teaching and research by the University, but principally for patient care services by the hospital. This situation left out of consideration remuneration for administrative services, such as divisional directorships and other variously time-consuming assignments. The result of these largely unsatisfactory arrangements was often confusion and dissatisfaction, which led to friction, not just interpersonally, but also among institutions—the University of Alberta, the University of Alberta Hospitals and in some situations the Affiliated Teaching Hospitals in multiple permutations and combinations. Subterfuges and compromises tended to result in which, for instance, the University and the UAH job descriptions did not agree. Disagreements arose on the basis of the UAH claiming that a teaching task combined with a patient-care service task required no discreet funding. Moreover, billing fee-for-service led to claims by UAH administrators of "double-billing" by hospital-funded academics, who for part of their

extensive time commitments, had only part-time salaries. Because their job descriptions defined the tasks and commitments inadequately, in some controversial situations, specialized (patient service) laboratory tasks, for instance echocardiography, could not be billed for. Further, because of prolonged delays in agreements to permit such billing, such functions had to be carried out without remuneration for extended periods.

The controversies on staff funding, overflowed even into questions concerning the stipend of student interns and the salaries of medical resident physicians. Questions arose whether the payments were for services to be rendered by these individuals, or by way of funding for studentships in the sense of educational support. Such problems of course were troublesome when students or residents brought up questions concerning the educational content of their services on behalf of patients. In such arguments, the emphasis tended to be on too many service functions being demanded without sufficient educational content. These matters were not defined adequately and remained unresolved in the period of time covered by my chairmanship.

Concerning the cost of teaching, there can be little doubt that clinical instruction slows down the teacher: at the very least, the necessary planning of teaching sessions (involving time and energy) needs proper remuneration. Unfortunately, excessively strict "academic" attitudes tended to regard teaching at the bedside as an "unplanned" activity and therefore of little merit and indeed requiring little compensation since the teacher was billing fee-for-service. The unfairness of that attitude was generally recognized as inappropriate by the second half of the 20th century. The history of attempts by our Department and the Faculty of Medicine in this regard are part of the Department's history

as mentioned in that chapter. Attempts at better compensation for part-time staff both at the ATH's and the UAH are appended to this report (Appendix VIII). These items speak for themselves. Their acceptance was general. Unfortunately as time went on there appeared to be ever less money available for compensation of the part-time staff.

b) Number of beds and their distribution

The enclosed Table 4 indicates how the Department's beds were distributed between September 1977 and September 1985. The Department's bed occupancy was a constant source of concern: the need to provide clinical teaching material in General Internal Medicine and the fairness in the distribution of these beds, as well as services, to the Department's role as a tertiary referral centre, dominated these concerns. As changes occurred perhaps the most striking devolution is to be seen in the General Internal Medicine component from over 70 to just 52 beds. The departure of part-time teachers in General Internal Medicine, was of course a problem, but it permitted this aspect of the bed redistribution to occur. The subspecialty staff compensated for the decreasing number of general internists by subspecialists performing, for at least one month each year, on the clinical teaching units in a generalist role. The obligation of subspecialists to act as general internists was, by and large, well accepted although there were some exceptions. For instance, some neurologists justifiably indicated that they had never undergone full training in internal medicine.

The untold story within the table as described, concerned the clinical investigation unit, which throughout my chairmanship, had eight beds. The subsequent sad decline in

TABLE 4. DEPARTMENT OF MEDICINE BED DISTRIBUTIONS UAH — 1977-1985

Year / Division	SEPT 77	DEC 79	MAY 80	DEC 81	JULY 82	JUNE 84	SEPT 85
Cardiology	25	25	18	21	21	21	26
Clin Hematol	7	7	7	6	6	6	9
Dermatol	0	0	0	0	2	2	0
Endocrinology	12	12	12	12	11	11	11
Gastroenterology	23	24	24	24	25	25	25
Gen Int Med	71	69	65	60	62	62	52
Inf Dis	7	7	7	6	6	6	9
Nephrology	14	16	16	16	18	18	22
Neurology	20	12	13	13	14	14	14
Pulmonary	25	25	25	25	26	26	29
Rheumatology	20	22	19	19	19	19	16
Coronary Care	6	6	9	9	14	14	9
Clin Invest Unit	8	8	8	8	8	8	8
Unassigned+2 dental	8	11	15	12	6	6	3
TOTAL	246	244	238	231	238	238	233

these bed numbers in the clinical investigation unit, ending in its virtual disappearance at this time of writing in 1993, is in stark contrast with the supposed intent of the Health Sciences Centre, by both the intramural planners and the Government of Alberta. The avowed intent was to create in the Health Sciences Centre a Clinical Investigation Centre for Northern Alberta in this tertiary care hospital. To most of us in the Department of Medicine, this indicated that the number of Clinical Investigation Unit beds ought to have increased. Clearly this did not happen in the time described by this report. That the very opposite happened in the years which followed is a sad reflection on our time, in terms of the balance of academic versus financial pressures.

ACADEMIC CLINICAL PRACTICE

1. Specialist versus Generalist

This controversy between specialists and generalists was recognized early during my administration. Almost upon my arrival I perceived an excessive emphasis on subspecialization. Moreover, I sensed a notion among the subspecialists in the Department that (general) internal medicine was a specialty of the past and without a future. I felt this was an inappropriate attitude with which I had to deal. After all, the majority of our residents train to become internists and all of them do so during the initial years. The controversy persisted throughout the 11 years of my chairmanship. However, I believe I made significant progress toward re-establishing the proper role and importance of general internal medicine. As part of my reforms, the subspecialists were involved in serving for at

least for one month each year as general internists on the teaching units. A few were enthusiastic in responding to the challenge, while all complied satisfactorily. Dr. McLean was one neurologist who made a special effort to do an internal medicine review, while Dr. Dossetor took repeated locum tenens assignments (on his own time) with a generalist brother. There were also those who protested, especially some among the neurologists indicating that they themselves were never properly trained as general internists. Certainly the concept of the need for general internal medicine to persist has prevailed in the subsequent years. It is clearly more widely accepted now, especially through the prodding of the Royal College and the American College of Physicians. The sequence that the primary training we give our graduate M.D.s (in specialty training), is first to have them be competent and certified general internists, and only then as subspecialists, seems little debated any more.

2. Characteristics of Academic Physicians

Recognition that the University's employment of Geographic Full Time (GFT) medical teachers is on the same basis as that for all other academic staff, helped to define this topic. This relates to the simple, direct statement that, employment by the University is for the purpose of teaching and research, and that other considerations such as clinical care of patients, important though they are, must be secondary to the principal bases for employment. Accordingly, appropriate individuals for academic medicine have to be primarily excellent teachers and researchers. This does not diminish recognition of the critically important part clinical teaching, with its focus on seeing and caring for patients,

has for our undergraduate and graduate students. Consequently, I viewed all clinical GFT staff as having to be well balanced among highly competent clinicians, superior teachers and more than just competent researchers. I also felt that GFT general internists had to be involved in scholarly activity with a scientific orientation. For this reason I sought among epidemiologists, clinical pharmacologists, and other clinically broadly based specialists for the GFTs of our general internal medicine staff. As I saw it, such clinical academics would see a wide spectrum of patients as general internists, but they would also have a sound scientific and scholarly base from which to do their research, as well as their teaching.

I had limited success in actually attracting such staff but my principles remained known, understood and appreciated and were more successfully accomplished by my successor.

TEACHING

Important educational issues during my chairmanship involved a number of topics in addition to the curricular debates on teaching the basic knowledge requirements of Medicine and the necessary clinical skills. To recount these issues in a logical sequence I group them under such headings as whom we were to teach, where and how. Concerning the how I mean with what attitudes on the part of the teachers and with what goals to be attained and what knowledge and skills to be retained by the students. The goals to which I shall refer shortly are additional to the mere acquisition of factual knowledge and basic clinical skills.

Much of what I am about to mention relates to clinical teachers as role models for doctors-to-be and specialists-in-training. The teachers' concepts of their role as physicians

and of their obligations as advocates of their patients are revealed to the students by the teachers' demeanor to both patients and to students. Much of what follows, apart from the selection of students (the whom) and Outpatient versus Inpatient controversies (the where), involves teaching by example for a professional lifetime of humanistic attitudes and good work habits.

1. Selection of Medical and Postgraduate Students

During my period of chairmanship, the prevailing attitude continued that virtually the only criteria for selection of medical students were their University or college grades. The concept was certainly strongly held, that marks were the only objective criteria, which no one could criticize or challenge. Unfortunately, on this basis, little attention was paid to aptitude or attitude of the students, nor to their communication skills or their past life and educational experiences.

An especially unfortunate matter was a policy of the outright resistance to the acceptance of individuals who had University degrees at a higher level such as Masters or Ph.D.s. The belief was widespread, that such individuals would not make use of their past training, for instance in science, or that, by virtue of having had more schooling than the average candidate, they would not persist with their medical education and drop out before getting the M.D. Finally, the notion was, that if they had a Ph.D. in a scientific discipline and got an M.D., they would not make use of both forms of training, but would either return to science exclusively, or do exclusively clinical medicine without regard to their past scientific training. Happily, these attitudes have changed in recent years, and after reviews of the medical school's selection processes, appropriate reforms have been instituted.

It was a marked contrast for me to experience the limited influence my colleagues and I had in the selection of interns, residents and subspecialty trainees at the University of Alberta, compared to my more than two decades at the Mayo institutions and the University of Minnesota. Rather than being able to select the best and most eager from among some of the brightest applicants in North America and beyond, we had to be satisfied with many who selected the University of Alberta and University of Alberta Hospitals by default. There was a normal statistical distribution among our postgraduate students of course, but, for instance few of our own best Alberta graduates selected us, and at least for the initial (general internal medicine) residency training years, we had little choice from among the best Canadian graduates. Some excellent candidates eventually found their way into Chief Resident, and subspecialty positions. Some among the best trainees eventually even became academic members of the Department. However, the average resident, once in the system, stayed until certification because there was no competition involved in promotion to Senior Resident positions in General Internal Medicine. Happily, the quality of our applicants improved, but not until a) our academic staff enlarged and b) favourable news concerning our high success rate on specialty examinations along with c) the improved facilities we developed, reached potential trainees.

As an aside, I would mention my favourable impressions of the superior verbal communication skills of Canadian resident physicians over their American counterparts. In my two decades with the latter, it was a struggle to stop them from reading their histories and other reports on rounds. The Canadians seldom failed at being well spoken extemporaneously.

2. Outpatient versus Inpatient Teaching

Criticisms around this topic were abundant in the Royal College reviews of our resident training prior to my time. Moreover, with my Mayo Clinic experience I felt it important that the doctors we trained have experience not exclusively with patients in hospital but also with realistic outpatient care under expert supervision. Outpatients have at least qualitatively different problems and require different attitudes and approaches to their problems, in contrast to patients who are sufficiently ill, that they have to be in the hospital. I was successful at least for a while (1976-1981) in having a solid block of time (of two or three months) for interns and residents to be working with their primary responsibility to the outpatient clinics with only "secondary call" to the Emergency ward and to hospitalized patients. The end to assignment of rotating graduate M.D. interns to the UAH and a decreasing resident staff forced the end of this beneficial opportunity—to my great regret.

Without outpatient experience, young physicians often had an unbalanced view of the significance of illness and of their own responsibilities to patients. A common and frequently displayed attitude by recent medical graduates (without outpatient practice experience) was that if a patient was not in a hospital bed, the problem was barely deserving of an M.D.'s time and attention, even if the patient suffered from such serious maladies as nephrolithiasis, or a neurologic disorder of a potentially disabling nature, or a potential malignancy, and that going beyond the point of diagnosis into therapy was "not in their (outpatient assignment) job description"! I persisted in emphasizing to my students, that satisfying patients (with information and treatment), and their referring M.D.s (with information and advice), was indeed in their "job description". More about this need to

satisfy patients and referring physicians in what follows.

3. Professional Role Concepts and Attitudes

a) Satisfying Patients and Referring Physicians

This is an important issue for all to recognize, both in the inpatient and outpatient settings. We, as physicians, are not just there to pursue science or make diagnoses about the existence of disease or its absence, but we must satisfy our patients and we must satisfy the referring physicians. This satisfaction includes the need to bring patients back for follow-up visits for adequate explanation of findings and recommendations. A call from a secretary to the patient, in lieu of the above, with the message "all was normal", is inadequate. As advocates of our patients we owe them reassurance even if the health survey is "negative". Likewise, referring doctors deserve a prompt report including answers to questions they posed, appropriate comments on their proposed diagnosis, and recommendations concerning the care and treatment of the patient.

b) Preventive Medicine

Another important issue, relating to and combined with the above topic of satisfying the patients and physicians is to recognize, that the most effective help we can render to our patients is to prevent disease or prevent the aggravation of problems or complications, rather than just dealing exclusively with only a short-term approach to the severest of their problems. A number of additional issues with regard to satisfying patients come together here. These include, not concentrating exclusively on the severest of the patient's acute problems, but dealing with the whole patient, and also educating patients in the management of chronic ailments such as diabetes mellitus or arthritis.

c) Attitude toward the Elderly

Here, the student revolt during the late 1960's and 1970's brought about a peculiar attitude. In part it supposedly involved friendliness to the elderly. This most often meant that the medical student or the young resident wanted to be called by his or her first name and in turn addressed the elderly patients (indeed patients of any age) by their first name. Such attitudes were (and, alas, have remained) wide-spread not merely among medical students and residents but also among nurses. It has been abundantly pointed out that such attitudes may be demeaning to the elderly, who often resent being so addressed (unless such is truly by their preference) and who also are apt to be relatively defenceless in the hospital or clinical environment. Once reduced to an involuntary child-like status, their protestations are of little avail or may even get them categorized as uncooperative or antisocial.

A somewhat related common attitude of medical students, upon being issued identification tags with their photograph and name on it, was to insist to have no other name on there but their first name, to promote the above-mentioned first name approach to all and sundry. I argued forcefully against this, perhaps with some success.

4. Good Work Habits

I have regarded this topic to be of major importance in our teaching, especially of the clinical year medical students and our post-doctoral students. I felt that the instillation of good work habits was a major desired residual of the medical school and post-doctoral training process. I argued that while many of the facts learned were often soon forgotten, good work habits remained. Examples of relevant good work habits are some of the following.

a) Completeness of Physical Examinations

In addition to a complete and well-taken, as well as well-recorded history, the completeness of the physical examination I regarded as an absolute essential. It was important that the examination not exclude for instance rectal examination or pelvic examination or the examination of the male genitals. All too often these were either completely ignored or a note made "deferred" (which then usually meant that it was never really attended to again).

b) Prompt Recording of History and Findings

This I emphasized on all levels (to staff as well as students) and often found wanting, in that the history often was not promptly enough recorded—especially because the physical findings tended to be left to memory and to belated dictation or writing, for instance only after ward rounds were completed. The actual making of some measurements (by rulers or callipers) of tumours, or skin lesions, or of enlarged organs needed to be recorded promptly to be accurate. The transcripts of dictation were sometimes not available for hours, days or even weeks. Ascertaining then whether the dictation was accurate or accurately transcribed became almost impossible. Clearly a part of good work habits for a physician is the prompt recording of findings. This is an example of the meeting of the Scientific Method and the Art of Medicine—that prompt, accurate recording of findings, which is part of the method of science, is also part of the methods a good physician employs.

c) Prompt Writing of Reports, Letters, Including Discharge Summaries

The delay of dictating the discharge summaries, often long after the patient has been dismissed from the hospital, is an example of bad work habits. Not only is it more difficult to reconstruct a patient's history, findings, and course in the hospital, as well as discharge

arrangements and recommendations, but also, much that needs to be communicated is both more accurately recorded and more easily recalled while the patient is still there, or immediately after discharge. Failure to contact the patients' referring physician concerning important developments or events (e.g. surgery or even death) is unpardonable conduct. I proposed repeatedly the adoption of the Mayo Clinic Discharge Summary method which, in the last years that I was at Mayo, had to be hand-written on a form, before the patient could be discharged. One copy was given to the patient, which the patient could then hand to the referring physician upon returning home, while another copy was to be mailed to the home doctor. Moreover this promptly and accurately hand-completed document became the patients' discharge record. Belated reports were to be added as they became available, by the attending physician and also transmitted to the referring M.D. I was pleased to see within the past year (about 1991) that the University Hospital has finally accepted such a form and a somewhat similar approach to the discharge of patients. However the dictation of discharge summaries—clearly a costly duplication of efforts, if the above "letter" is well composed—is still required.

An important issue relevant to this matter and related to good work habits, is that a major factor in the satisfaction of referring physicians, relates to the promptness with which they receive reports about their referred patients. The simplest and most prompt way of reporting is, of course by telephone to the home physician about important major events. If this is not done, the referring doctor can (and occasionally does) find out about such tragedies as the demise of his referred patient belatedly and not from our Staff but from the grieving relatives.

RESEARCH

Progress and problems in the development of the Department's research profile were related to funding, research space, recruitment and various aspects of the Department's function as a research entity. For clarity of exposition, despite their inter-relatedness, I will deal with these under individual headings.

1. Funding

This topic readily subdivides further into headings of personnel support and project grant support as well as the demonstration project of the Muttart Diabetes Research and Training Centre.

a) Personnel Support

The University's ability and willingness to provide geographic full-time funding declined and with it the support of full time new positions had increasingly to be sought on the basis of extramural funding. Sad to tell, I understand that in years beyond my chairmanship, matters progressed to a state when even office supplies and basic services such as telephones had increasingly to be obtained from other than University funding.

Fortunately, my chairmanship included the era when the Alberta Heritage Foundation for Medical Research (AHFMR) came on the scene with the specific aim of supplying personnel funding. True to its commitment, the AHFMR did supply, after almost excruciating scrutiny, such funding for the various levels of staff appointments and even studentships and fellowships. In the initial years, it was truly the applicants and the excellence of their applications that determined the outcome. More recently, funding limitations were a major factor as well. Of course, scholarships (and even the Medical

Research Council, [MRC] associateships) remained available from sources other than AHFMR, sources such as the Alberta Heart Foundation, Canadian Arthritis and Rheumatism Society, the Canadian Diabetes Association and others. These were all carefully peer-reviewed. To varying degrees, these funding sources insisted that the University, after a number of years take over a successful candidate. Such conditions did not apply directly to AHFMR. While AHFMR conducted three to five yearly reviews and reappointments were possible, the lack of security (tenure) of the AHFMR appointments has been and has remained an unresolved issue. It was of course never anticipated that the University would or could take over all of the AHFMR's appointees.

b) Project Grant Support

These, excepting for ad hoc start-up supports, were not intra-murally supplied. A notable exception has been the Special Services and Research Committee of the University Hospitals. At least through 1986 this source of funding was crucial for many start-up or pilot projects and at times came to the rescue when extramural funds became temporarily unavailable. Excepting for the necessary and appropriate ethical scrutiny, the Special Services and Research Committee's decisions did not truly come on a peer-reviewed basis.

On the other hand, from MRC and other granting agencies, funds could be obtained only after extensive peer scrutiny, which is of course the desirable way for funds to be awarded.

There has, however, been a growing segment of private funding for a number of investigators from grateful patients and their relatives or private foundations or special organizations, which were persuaded to support research at the behest of persuasive staff members. The University and the University Hospitals Foundation and administration at

various levels, have worked hard to define better the conditions under which such funds could be accepted, to make sure that ethical conflicts were avoided and that the funds were handled in a responsible manner. There has, of course, never been any problem (to my knowledge at least) of inappropriate handling of funds, as all funding had to be managed according to University and University Hospitals' regulations. However, without the peer-review and the careful elaboration of research plans and scrutiny at multiple administrative levels before funds are awarded, there remained serious questions about the soundness of private funding of research projects.

c) *Demonstration Project: The Muttart Diabetes Research and Training Centre*

A combination of factors could be and indeed was brought into play with regard to funds from private foundations. One of these concerned the establishment of the Muttart Diabetes Research and Training Centre. As I describe below, the University of Alberta was the right place and the late 1970's was the right time for creating a Diabetes Research and Training Centre. In addition, the constellation of other factors, such as the Gladys and Merrill Muttart Foundations' interest in diabetes mellitus[1] and the objective attitude of its Board of Directors, which included Emeritus Professor D.R. Wilson (knowledgeable of the peer review methods of the Medical Research Council), encouraged me to apply to that potential source of funding. I saw also the opportunity to make a demonstration project for the University and my colleagues of the benefits obtainable from taking comparable care in designing the application to the standards of the National Institutes of Health in the USA (in my personal past experience) or those of the MRC in Canada. Such an application

[1]Both of the deceased founders had been diabetic. Mrs. Muttart had been the first President of the Canadian Diabetes Association.

required more work, but also made success more likely, and justified the request for significantly larger funding, than the more-or-less casual approaches had theretofore yielded from private foundations. I submit that the careful preparation of this application, and the peer-review it received at the behest of the Muttart Foundations' Board, both contributed to the Centre's long-term success.

Some aspects of this special project and my personal relevance to its origins are the following. During the early 1970's, the United States Congress enacted its diabetes law, establishing special assistance for research funding for intensified research of diabetes and the training of diabetes researchers. Ten diabetes research and training centres (DRTC) were established at major U.S. medical centres with funding for laboratories, pilot feasibility studies and the facilitation for research groups, to attract additional extramural funding, as well as to attract outstanding scientists to the diabetes research fields. In my final years at the Mayo institutions I tried to bring about a joint application by the University of Minnesota and the Mayo institutions on the basis of our well-recognized joint strengths in diabetes research and education fields. I brought with me to Edmonton in 1975 the same ideas of a DRTC here. Knowing of the history of diabetes research at the University of Alberta, going back to J.B. Collip's time in the early 1920's, (which resulted in Dr. Collip sharing in a 1922 Nobel Prize) I put together a University-wide interdisciplinary application, in association with some ten scientists and physicians, to The Muttart Foundation. In the spring of 1981, after multiple intra and extramural reviews this application was successful in obtaining $1,200,000 to establish the Centre (with an additional $103,569 for equipping the Core Laboratories). The financial basis was the Alberta Government's Advanced Education Department's agreement to match the endowment's interest earnings for a period

of ten years. By then (1991), the endowment had nearly doubled and the Centre's function in terms of staff and productivity quadrupled, culminating in the attraction of Dr. Alex Rabinovitch as my successor to direct the future years of the Centre. By then, the MDRTC had also clearly attained international recognition on the basis of its accomplishments. On the way toward the tenth anniversary, but actually already in 1986, just prior to the end of my Department chairmanship, the Centre organized an International Symposium on Immunology of Diabetes. In attendance were 266 registrants representing 20 countries.

My colleagues and I felt that the interdisciplinary character of the membership of the Muttart DRTC, was important to emphasize and to maintain. There are now staff members from 13 different departments from 5 faculties of the University of Alberta, though a majority of the clinicians among the members are in the Division of Endocrinology and Metabolism in the Department of Medicine. Consistent with the University-wide, interdisciplinary theme, I continued to emphasize that this Centre was not an integral part of the Department of Medicine nor of the Division of Endocrinology and Metabolism.

Although I was the principal applicant, the proposal was a true collaborative project. Significant input was provided by many, but key contributions came from Doctors Just Elbrink (Pharmacology), D.M. Fawcett and A.R. Morrison (Medicine), T.H. Leeson (Anatomy) and W.A. Bridger (Biochemistry). In addition, much wise and helpful guidance was provided by Dr. D.R. Wilson and Dean Cameron. Even so, we had several re-submissions to make before receiving the final approval.

2. Space

By the late 1970's this was indeed a serious problem in terms of laboratories and

related facilities. So much so, that beyond the very first AHFMR personnel award appointee, it became a critical issue. After suitable definition of the specifics, but especially the magnitude of the problem, AHFMR, the University, and the University Hospitals had to recognize the problem and plan to deal with it. The outcome of prolonged deliberations was the highly beneficial decision, which resulted in the Heritage Medical Research Centre building being planned and built. In the meantime, availability of research space in the Alberta Research Council building and on the top floor of the newly built Canadian Red Cross building, permitted continued development of the research arm of the Department of Medicine and that of other departments, of course, as well. These buildings still house portions of the Department of Medicine research facilities several years after the Heritage Medical Research Centre has been built and occupied.

3. Recruitment

Integral to the recruitment process are the considerations of funding and space upon which I have already commented. The security of the funding, be it from an extramural source, or the University, or tenure, was of course in every instance a critical and sometimes crucial consideration. As we were looking for successful researchers, other than among recently trained junior candidates, such individuals logically asked why they should leave secure positions elsewhere to come to an apparently insecure one. In some cases the Faculty was asked to "mortgage a position". This meant that an existing position had to be guaranteed, within the table of organization of the Faculty and the Department, for the eventuality that the extramural funding should eventually expire. It is to the credit of the recruiters at the various levels of University, Faculty, Department, Division and individual

enthusiasts, that as many good candidates as we were actually to recruit, did succumb to our blandishments when it came to the security issue. Another view may be that the University, AHFMR or other sources, plus the growing number of good scientists and clinicians among us, provided sufficient attraction even without guaranteed long-term security.

As the text and appendices of the historical chapter documents, a "critical mass" (a very popular phrase at the time) did indeed develop in the Faculty of Medicine and in the Department of Medicine in particular. In the diabetes field, as already indicated with the establishment of the Muttart DRTC in Endocrinology and Metabolism, but also in cardiovascular, gastroenterology, pulmonary and indeed in most divisions of the Department, effective interactive scientific groups developed during this period and virtually all of it on AHFMR personnel funding. Moreover, the establishment grants for the few university GFT positions, which we were allowed to fill on the basis of vacancies, further provided the proper equipment and start-up funds to assist with the development of the "critical mass". Additionally, equipment grants and some equipment maintenance funding were available after peer-review from AHFMR as well. These could be and were requested, not exclusively by Heritage appointees, but by GFT University Academic staff as well.

The geographic location of Edmonton often played a role in an unfavourable way when it came to recruiting individuals, especially from eastern Canada. The view from the East has always regarded anything west of Toronto as provincial, further to which Edmonton's location conjured up, in the minds of eastern Canadians, a special degree of remoteness, lack of development, and a much more extremely northern location than was fair or realistic. To the Centres in eastern Canada and the eastern U.S., Edmonton is indeed far removed. However in the late 1970s and early 1980s, communications by air

to both east and west in Canada and to the U.S. and indeed even overseas were excellent in terms of ease and directness. This was exemplified by the polar route to European centres. Alas, in the 1990s many of these advantages of access to Edmonton's have been sadly diminished.

Fortunately, with the satisfactory display to potential recruits of the favorable developments at the University of Alberta and of cultural and educational aspects of Edmonton, successful recruitment has not remained an overwhelming problem.

4. Functional Aspects of Research in the Department

a) Internal Research Communication

Numerous methods were tried for communicating with colleagues, graduate students, residents and members of other departments about research being done by Departmental members, but none went well. For instance the monthly Departmental Research Seminars proved unsuccessful and were discontinued in 1981. A more successful means of sharing information at least with colleagues, was the compendium of first pages. This in effect was a yearly internal re-publication of abstracts of the various staff members publications. The results of research were also communicated from time to time during Grand Rounds. However, with the development of research groups and Centres, these units predictably proved to be more effective means of conveying information and of promoting interactions among investigators.

b) The Clinician-Scientist Mix

Some scientists, especially in the basic disciplines may justifiably ask from time to

time: what are properly trained productive and even successful scientists doing in a *clinical* department? The answer is readily apparent on scrutiny of most successful major medical schools in North America. Indeed with the growth of research effort and personnel in our Department of Medicine, the productivity of both clinician investigators and their scientist colleagues within the department have well-documented reasons to be satisfied with such geographic and administrative arrangements. It is evident, that in modern research, quite fundamental techniques are often essential to enable investigators to proceed. But so are the clinically knowledgeable colleagues and the closeness of interactions with them, to perceive the problems in clinical medicine for both the identification of the problem and the ultimate delivery of benefits from research to the bedside.

In the Department of Medicine, successful interactions and coexistence among basic and applied scientists and clinicians has worked well. This has especially been the case when the laboratory scientist was located in departmental laboratories. However, successful collaboration by clinicians and clinician-scientists with members of basic science departments and indeed with colleagues across the campus in Faculties other than Medicine, has also been satisfactory and often very successful. Most unbiased observers, who have had experience personally or by observation with both arrangements, tend to favor the location of at least some of their basic and applied colleagues and collaborators within the same Department.

Two important sets of interpersonal arrangements were important to me for successful integration of scientists in a Department, which also had a major mission for patient care. One was that by definition the clinicians had to outnumber the scientists for an adequate work force to accomplish the Departments' clinical mission in patient care and

undergraduate and postgraduate education. The history of Mayo institutions as well as that of other clinical academic centers had shown that excessive numbers of nonclinical scientists among clinicians did not work well.

The other arrangement had to be an explicit commitment by the clinicians not to exploit their scientist colleagues. Mutual respect has to exist with understanding of the different goals, missions and special working conditions of the two sets of staff. This is not always easy, as the rewards of the two groups are apt to be different. But nothing is more disruptive than the sense of exploitation, when scientists perceive that their clinical colleagues attempt to reach their academic goals not by true collaboration, but by exploitation.

I have had the good fortune to see the spirit of genuine collegiality among scientists and clinicians throughout the Department of Medicine during my years of Chairmanship. Especially close at hand to me was the Division of Endocrinology and Metabolism. It, at times, had nearly as many Ph.D.'s as M.D.'s working in remarkable harmony under the able leadership of Peter Crockford.

c) Clinical Research

Extreme purists have from time to time decried any "non-fundamental" investigation, indeed any investigation involving patients, as examples of dabbling by amateur clinician-researchers, not even worthy of being called research. This is obviously an extreme point of view, well and often refuted by the annals of science and medicine. I have always emphasized the application of scientific principles to the practice of medicine. Well-planned clinical investigations, in my opinion, are the very core of academic medicine. Looking

scientifically at clinical problems, evaluating well-defined problems objectively with proper protocols, even re-examining recent advances not yet adopted clinically, and also getting first-hand experience with new therapeutic agents, are just a few examples I deem as essential activities in a first-class Department of Medicine. Without such well-designed inquiries, reviews and organized undertakings, the relationship of the clinical staff with their scientist colleagues on the one hand, and with their students and patients on the other, simply cannot be in proper balance. It may be perhaps redundant to state, that the clinician who never deliberately experiments in a well-planned way, with proper analysis of his data and who does not proceed to report the results, does not belong in an academic Department of Medicine.

d) *Graduate Students*

I draw the distinction here between post-graduate students, such as our medical residents and Fellows in subspecialty training, and the graduate students who are working towards advanced university degrees such as Master of Science and Ph.D. under the supervision of a basic or clinical scientist. The research and the educational plans of graduate students and proper scrutiny of their activities by an appropriate supervisory committee, responsibly supervised by departmental and faculty authorities, are essential building blocks of an academic department composed of clinical and basic scientists, as well as clinicians. It is inconceivable for me to agree with the criticism of some, for instance the extramural PACCR committee in 1984, who questioned "the excessive scientific educational ambitions" of our department, for having as many graduate students as we did. The academic record of these students and their supervisors speaks for itself. But how could one accept the appropriateness of members of our Department doing research without also

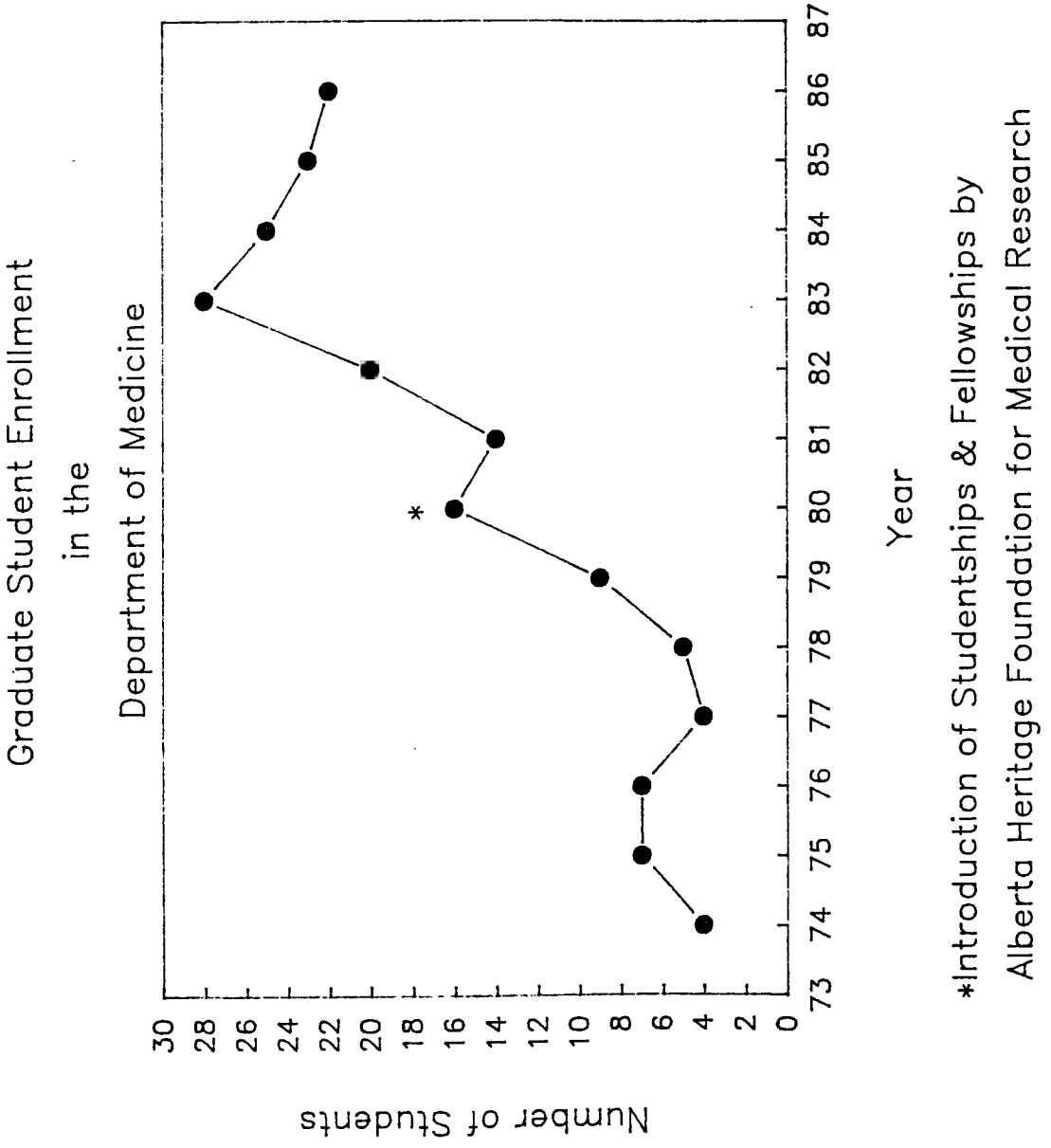
accepting the concept, that they have a right and indeed an obligation to have graduate students, whom they train to be scientists. These students, of course, benefit from the competence, sound planning, funding and experience of the Department's staff members. Undeniably, these students also contribute to their supervisor's work force and the teacher-student interaction is the kind of stimulation, that few sound and well balanced researchers would be willing to do without. The Department is proud indeed of the growth in numbers, of its graduate students (Figure 3), which went right along with the growth in staffing, funding and productivity in research of the Department.

e) Research and Resident Training

A regularly occurring criticism by Royal College periodic reviewers of our specialty training programs concerned the lack of research exposure of our residents. They not only criticized this here, but in every medical centre. Indeed, the American College gives the same criticism in reviewing resident training programs in the USA. There is, of course, a drive by the residents to get their training years behind them and to enjoy the independence and financial benefits of specialty practice, without getting involved in time-consuming research training and delays, at only moderate financial compensation, and with only remote prospects of a potential academic career.

The situation was much different during the middle years of this century, for instance at the Mayo Clinic and the Mayo Graduate School of Medicine. It was absolutely obligatory for every Mayo Fellow to spend at least six months on a formal research project. The projects were often chart reviews or pathologic tissue reviews or surveys. Longer time commitments of 9 months to 1 year and even longer on active research undertakings were also available. The experience provided a critical understanding of the literature and an

Figure 3.


Graduate Student Enrollment
in the
Department of Medicine
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Year
*
*Introduction of Studentships & Fellowships by
Alberta Heritage Foundation for Medical Research

acquaintance with some laboratory techniques, but above all it provided the acquisition of an attitude of objectivity, which at least in retrospect, every Mayo Graduate ultimately cherished. Walter Mackenzie himself having experienced the Mayo system as a Fellow in surgery, introduced it to the University of Alberta Department of Surgery. To this day this is carried on. Of course, when combined with animal surgical techniques, this is a highly appropriate commitment of time for surgical residents. However it is a pity that no equivalent (except for a nominal and minimal allowance of time for research) exists in a systematic way, during the training years for the Fellowship in General Internal Medicine. Even during subspecialty training, the degree to which trainees become acquainted with the laboratory techniques of their future subspecialty leaves much to be desired.

It is unfortunate as well, that such approaches as the previously mentioned (Internal Research Communications) Departmental research seminars, to which residents were finally and belatedly admitted, have failed. This is so, because our residents generally have no knowledge of and perhaps because of that, very little interest in, the research activities and accomplishments of the academic staff. Under such circumstances it is understandably difficult for even motivated research staff members to convey their investigational enthusiasm to the residents.

Matters have actually improved through the availability of AHFMR fellowships and studentships for better-funded, as well as better-planned, training of individuals with academic interests in applied science (and occasionally even in basic science) for application to clinical science. Such training, both locally and in other centres, has produced outstanding new candidates for our staff. An incidental benefit of this program therefore, has been one means of overcoming geographic problems for recruitment, when a medical

resident already on site has shown the interest and aptitude to apply for an AHFMR fellowship. This of course invariably required the appropriate staff guidance, to produce the kind of application which had a reasonable chance of success. I have been pleased to observe successful progress in this area, under the combined stimuli development of research in the Department of Medicine and the enlightened approach of the AHFMR.

CREDITS

Consistent with the series title "As the Chairman Saw It"—a phrase coined by my successor Dr. Garner King—the foregoing represents my personal account of the years 1975-86 in the life of the Department of Medicine. I take responsibility for the statements and views expressed. Any errors or omissions are mine as well.

What the Department accomplished is, however, the work of its staff, academic and non-academic, whose contributions need more acknowledgement than I have so far been able to give. As I embark to give credit succinctly to those who appeared to do more than just satisfy the basic University academic requirements in contributing to the Department's welfare—I am again on my own—for I write from my point of view. More specifically, I write from our records of meetings, events and periodic reports, but also from my memory of how individuals and their actions and accomplishments appeared to me. I did take due note of the departmental members' views as well, in so far as they were known to me. I emphasize, that my thumbnail sketches are primarily oriented toward each individual's departmental contributions, rather than all-round mini-biographies. Again, the account is mine as are any errors or omissions.

Although not a member of the Department of Medicine, a special note of

appreciation is due to Dean D.F. (Tim) Cameron. His unfailing support of the Department, its individual members and of the Chairman was a major factor in our welfare while he held office. His wide administrative experience, kind understanding and fair oversight in matters within the Faculty, the University or in the concerns affecting within—or inter-hospital problems made it a pleasure to deal with him. His gentle humour provided just the touch to make some difficult issues easier to live with.

Upon Dean Cameron's retirement in 1983, Dr. R.S. Fraser was acting dean until the latter half of 1984, when Dr. Douglas R. Wilson assumed the leadership of the Faculty of Medicine. During the initial years of his deanship, Dr. Wilson's direction of the Faculty emphasized his principal concerns with academic standards and with fiscal restraints.

As the University's Chairman of the Department of Medicine is also in the same position in the University of Alberta Hospital's Department of Medicine, Dr. Bernard Snell the hospital's President, was an important figure in my contacts with the University of Alberta Hospitals. Intellectually, he was a most stimulating leader. Although we often differed in our points of view, our discussions were always amicable and had productive outcomes. The University of Alberta Hospital's Vice-President (Medical) was Dr. John G. Read, whose helpful interest in the Department and whose useful guidance in our joint affairs was readily available.

With these comments and cautions out of the way—to paraphrase the ends of movies and videos—"Let the credits roll!"

In the order of their appearance—I start with comments about colleagues who were present as I joined the Department.

Peter M. Crockford was an extraordinarily effective and energetic Director of the Division of Endocrinology and Metabolism. I considered Peter unique among endocrinologists world-wide because he managed to gather and to retain in his division endocrinologists concerned with all fields of that specialty from such disciplines as gynecology, pediatrics and urology. He also gathered and sustained the richest mixture of clinicians and scientists in the Department. Wonderfully humorous in lectures and clinics—whenever appropriate, his outpatient clinics for undergraduate and graduate teaching were and have remained the models for the Faculty. He was fiercely protective of his turf—for the benefit of students, patients and colleagues alike.

J.B. (John) Dossetor was a true "triple threat": As much at home in the clinic or at the bedside as at the bench in Nephrology-Clinical Immunology and appropriately the Director of that accomplished and effective Division. He was versatile in taking on the role of general internist when necessary, and in sustaining the Department's and indeed the Faculty's prestige in being our only MRC Associate. Much of the time he chaired our research committee and was invaluable as the first Long Range Planning Committee Chairman. His analytical insight contributed in major ways to the solution of many a problem we had. He was there when needed, with patience, wisdom and bon mots.

R.S. (Robert) Fraser my predecessor was a formidable presence, working quietly and effectively with knowledge and competence. He capped his career as Acting Dean in 1983/84 with great administrative skill and dignity. Unfailing willingness to help and quiet insistence on precision were among his hallmarks.

J.A.L. (Alan) Gilbert had been a teacher of mine during both undergraduate and internship years. He was a masterful teaching clinician as well as a model academic. More

than that, he was a diplomat without equal as he remained for so many years the Department's academic bridge-head and scholarly representative at the Royal Alexandra Hospital. His yearly teaching sessions to the graduating class (for preparation for the Licentiate of the Medical Council of Canada examinations) were without a doubt the basis of the U of A's good performance on the LMCC's nationwide comparison year after year.

R.N. (Neil) MacDonald headed the W.W. Cross Cancer Institute. Despite his heavy administrative commitment he was an all-round academic hematologist-oncologist who also accepted major departmental administrative assignments. He was always a sound and dependable advisor.

George Monckton directed the Division of Neurology initially. Then and subsequently his teaching and research were exemplary, as were his undertakings for the Department in guiding the clinical practice committee.

R.E. (Dick) Rossall was a supremely effective cardiologist and Director of the Cardiology Division. An innovative teacher at the forefront of computerized technology of instruction, he continued to embody the almost legendary image of masterful British clinical cardiologists. He developed his Division with great foresight. He had productive interactions with the Alberta Government as a special consultant to the Minister of Hospitals and Medical Care. Even though he was Associate Dean for a while, and was among the most sought-after cardiologic consultants, he did research and contributed generously to the Department's activities whenever called upon.

Brian Sproule was Acting Chairman of the Department prior to my arrival. He instituted such sound reforms during that year that virtually all of them were retained for the benefit of the Department in communications, organizational arrangements with the

affiliated hospitals, the grand rounds and many others. A creative pulmonologist and among the most respected in all academic phases in his field throughout Canada, Brian's reputation continued to soar and also to be appropriately recognized with honours as is evident in several of the appendices to this Departmental Report. Initially as Clinical Practice Committee Chairman and later as Vice Chairman, Brian was always there with competent advice and willingness to help in an unselfish, quiet but most impressive way.

D.R. (Don) Wilson, one of my predecessors, had also been my teacher. He continued in the Division of Endocrinology and Metabolism until his retirement in 1978. He was, of course, primarily occupied with the directorship of the MacLachlan Centre for the Royal College of Physicians and Surgeons of Canada. His sound, always helpful and wise counsel, was both useful and a delight to obtain, both before and after his retirement until his death in 1991.

L.M. (Lee) Anholt was a Director of the Division of General Internal Medicine, a role to which he eventually returned. He was most active and accomplished as a clinical teacher and in the administration of both clinical undergraduate education (as Phase III Coordinator) and resident training (as Director of Resident Training), not just in the Department but also for the Faculty (as Assistant Dean for Postgraduate Education). His direct and energetic approach got things done with an unfailingly optimistic mien.

N. (Nick) Bruchovsky was an endocrinologist and major research figure in the field of steroids. He often voiced alternative views on departmental problems with sound logic and depth. He left in 1979 to become Chairman of the Endocrine Department of the British Columbia Cancer Unit in Vancouver.

D.M. (David) Fawcett was very good at bridging the gap between Laboratory

Medicine, where he headed the endocrine laboratories, and our Department and of course the Division of Endocrinology and Metabolism. He was a most readily available, helpful consultant and teacher. He carried a major load in the Phase II teaching of Endocrinology and Metabolism. He also made major contributions in the development, establishment and function of the Muttart Diabetes Research and Training Centre.

George Goldsand directed and established the Division of Infectious Diseases. He played major roles in the residency training as Director and in the Department's Education Committee on educational planning and reorganization. Even when he became Associate Dean for Post-Graduate Education he always remained a major resource for solving the Department's problems. He was a masterful teacher and a founding parental figure of the infectious disease field in Canada. He continues among the most respected figures of our Department for his many contributions.

Charles "Chuck" Harley as an energetic general internist was the full-time academic chief of the Charles Camsell Hospital's Department of Medicine. His effective teaching and good organization made that affiliated hospital one of the students' favorite, and with good reason. As an academic he demonstrated that you could do a worthwhile sabbatical despite being a generalist. His studies of osteoporosis during that time were a fine accomplishment on which he appropriately followed up. He moved to the role of Associate Dean for Undergraduate Education with vigour and played major roles in Faculty and Departmental curricular reforms.

E.G. (Garner) King was a brilliant, creative and enormously energetic leader among the younger generation of academic staff members during the early years of my Chairmanship. He built up a city-wide network of teaching, service and research among

critical care medicine units in the various hospitals. At the same time he became nationally and internationally recognized as a leader in that specialty along with pulmonology. He accomplished much more still as he succeeded me as Chairman of the Department of Medicine. As he tragically died in 1992, others will have to account for his highly productive years at the helm of the Department.

D.R. (Don) McLean succeeded George Monckton as Director of the Division of Neurology. Don was a very lucid and direct teacher and contributed well to the organization and problem solving efforts of the Department.

T.A. (Alex) McPherson was a remarkably high-profile leader and contributor within the Department. From a unique base of being a fully qualified basic immunologist and also a clinician and Director of the Division of Medical Oncology and also of the Department of Medicine at the W.W. Cross Institute, he was the principal "evangelist" for matters academic in the Council of the Chiefs of Medicine of the Affiliated Teaching Hospitals. He continued to have an impressive record of peer-reviewed research funds and appropriate research accomplishments. He was an effective and popular teacher not just of oncology but also of internal medicine. While doing all of the foregoing, he managed to handle an Assistant Deanship for Research and in successive years presidencies of the Alberta Medical Association and later of the Canadian Medical Association. His later career turn was to become Deputy Minister of Hospitals and Medical Care and at the time of this writing President of BioMira, a highly innovative producer of pharmaceuticals and technologies in the health care field.

J.S. (John) Percy—among the most dynamic members of the Department, John

founded and directed the Division of Rheumatology. He directed it with vigour and moved it to the front rank of that specialty internationally. The academic activities of that division despite its small membership continued to be most impressive, so much so that year after year from distant corners of the world impressive young academics came to do clinical and basic studies as Visiting Members with his team. Both within the committee on long-range planning activities and as coordinator of Health Sciences Centre planning, John's work and voice were formidable and effective on behalf of the Department.

A.S. (Tony) Russell ultimately became John Percy's successor as Director of the Division of Rheumatology. Earlier he was Research Coordinator for the Department. He later became departmental and ultimately Faculty Ethics Committee Chairman. Tony in his witty and incisive way accomplished much on the Department's and the Faculty's behalf. He too established world-wide stature for himself and Alberta in rheumatology as a superb teacher and investigator, truly an all-round academic.

R.F. (Russ) Taylor: A quiet, effective man of many talents, Russ exhibited a remarkable combination of an outstanding invasive cardiologist who nevertheless stayed close to his roots in general medicine. The Coronary Intensive Care Unit was appropriately named after him, as it truly represents a living memorial to his cardiac teaching and patient care activities. He was invaluable as departmental Vice-Chairman during my final years of chairmanship. His untimely death in 1987 was still a great blow to the Department. Even though he was officially Emeritus, he continued as an active teacher as well as a general internist.

W.M. (Fred) Weinstein was a leading academic gastroenterologist who was also active

in educational affairs of the Department. Regrettably he was lured away to the University of California in Los Angeles in 1979.

J. (Joe) Dvorkin was a pioneer among Alberta cardiologists. He too had been a teacher of mine. I was to have only a brief time with him prior to his untimely death in 1976. His great popularity as a teacher and practitioner is commemorated by the Doctor's Lounge in the W.C. Mackenzie Centre's being named after him.

J. Frank Elliott had also been a teacher of mine. He continues to represent the finest in general internal medicine as a "teacher's teacher" and a "doctor's doctor". His wise counsel was much sought after and continues to be so to this day. At the time of this writing (1993) he is still in active clinical practice, even though retired from the University as Distinguished Clinical Professor of General and Internal Medicine in 1981, having been appointed to that unique title in 1978.

W.R. (Bill) Black was an effective Chief of Medicine at the Royal Alexandra Hospital. He continues to be a leading cardiologist and clinical teacher to the present.

Gordon Brown was a subspecialized clinician in diabetology. He had a well-deserved wide reputation for his excellence in his chosen field, as well as for the establishment of model diabetes patient-teaching centres at both the Edmonton General and the University hospitals. The excellence of these centres continues to command world-wide attention, well beyond his year of retirement in 1986. Prior to that he deservedly acquired the title of Distinguished Clinical Professor in 1981.

A.M. (Buzz) Edwards. The generally acknowledged Oslerian physician of the Department Buzz found himself seemingly at home in all the subspecialties. Officially a member of the Divisions of General Internal Medicine and Endocrinology/Metabolism, he

was always ready to quote the latest from the literature on seemingly any subject. He was Divisional Director of General Internal Medicine from 1978 through 1986. As Residency Training Director he was especially effective and admired for getting our residents to the front ranks of success nation-wide on Royal College specialty examinations. He ably coordinated our weekly departmental Grand Rounds. Among his many successful accomplishments were the internationally acclaimed American College-Royal College joint biannual courses in Internal Medicine in Banff over many years.

R.N. (Rod) Eidem. As diabetologist and generalist, he was a much sought after consultant and teacher. He was a Chief of Medicine at the Edmonton General Hospital and on several committees involved in departmental problem solving.

H. (Harold) Jacobs, was a much respected erudite neurologist and teacher; his wise counsel was often sought and readily given.

R.W. (Dick) Sherbaniuk Alberta's first gastroenterologist and founder of the Division of Gastroenterology and its original divisional director, he was again called upon to direct the Division from 1981 to 1984. One of the major teachers of his specialty nation-wide he remains appropriately respected as a productive academic. Somehow Dick has found time to be a major figure as President of the Alberta College of Physicians and Surgeons with important roles to play in a range of societies from the Alberta Medical Association to the Royal College and in national and international societies of Gastroenterology.

J.H. (Jack) Sprague. He continued to be an important figure in General Internal Medicine with a subspecialty interest in peripheral vascular diseases and hypertension. He was active in the resident training field, which he had directed in an earlier period.

R.H. (Ron) Wensel. Outstanding for his boundless energy and dynamism, Ron

continued to be a model of the productive academic even though for the period of this account he remained in private practice. He was Divisional Director of Gastroenterology and Director of Health Sciences Centre Planning along with numerous high level commitments to provincial, national and international clinical organizations. Not surprisingly, he later became a full-time academic and eventually Vice-President (Medical) of the University Hospitals. He was member of the Executive and Clinical Practice Committees in addition to his many other intra- and extra-mural commitments.

T.H. (Ted) Aaron. The senior allergist of the province and of our Department, Ted has belatedly been recognized through membership in both the Divisions of Immunology and Nephrology and General Internal Medicine. An internationally recognized authority, his wise counsel was often sought.

J. (Jack) Brown. He was Director of the Division of Dermatology from 1975 through 1982. Quiet and unassuming, he has remained a major teacher of his specialty to the time of this report.

F.A. (Alex) Herbert. A uniquely independent academic and a major teacher of pulmonology, Alex could always be depended upon to voice another point of view. His sound but often dissenting opinions and recommendations were a source of major strength to the Clinical Practice Committee, on which he served, and to departmental meetings and councils.

R.L. (Dick) Jones. A major teacher and researcher in pulmonary applied physiology, Dick did important work on numerous committees including Clinical Practice and Health Sciences Centre planning.

F.G. (Fred) MacDonald. A versatile teacher and researcher, recognized early for his major teaching role, Fred remained an important advisor to departmental councils long after he had been Chief of Medicine at the Edmonton General Hospital. He returned to important functions at the helm of the Department of Medicine at the Edmonton General Hospital in association with Dr. McCaffery. Meanwhile he continued as a productive and nationally and internationally respected pulmonologist.

C.J. (Chris) Varvis. An important teacher and general internist at the Royal Alexandra Hospital he also played a major role on the initial Long Range Planning Committee.

S. (Sam) Weisz was Chief of Medicine from 1981 through 1983 at the Misericordia Hospital and an important activist in the increasingly academic orientation in the Department of Medicine at that affiliated teaching hospital.

E.A. (Anne) Fanning. The leading expert in the tuberculosis field and other aspects of Infectious Diseases, she later directed that Division. Forthright and clear, her advice was sound and valued in Departmental discussions.

J.M. Goodhart. A forthright, effective Chief of Medicine at the Royal Alexandra Hospital, his term saw controversies but also positive developments in teaching and interactions between the Department and his hospital.

J.T. (Jim) McCaffery. Chief of Medicine at the Edmonton General Hospital from 1981, during some years in association with Dr. MacDonald. Some important problems were solved during his term through his effective leadership.

A.F. (Fred) Wilson. A respected teacher of Neurology and Chief of Medicine at the

Royal Alexandra Hospital from 1980 through 1982, a quietly effective leader who promoted harmony among the affiliated teaching hospitals.

D.J. (Del) Tusz. He took over the role of Chief of Medicine at the Charles Camsell Hospital as Dr. Harley was increasingly involved as Associate Dean of Undergraduate Education.

E.H. (Elwood) Shell. He became the Administrative and Professional Officer of the Department just prior to my chairmanship. He continued most effectively in support of administrative activities throughout my chairmanship. As Chuck Morrison joined us in 1978 and as the Department grew in all activities, Elwood was able to concentrate on the important tasks of financial and personnel administration. Despite the almost geometric expansion of the research accounts (and with it the growth of research but also of other support services and personnel) he unfailingly kept order in the often convoluted fiscal and much expanded personnel affairs of the Department. He consistently provided excellent support to the Department Chairman and Divisional Directors through his good work and dependability. To many of the staff, academic and non-academic alike, seniors and juniors included, he was somewhat of a father confessor.

The foregoing were members of the Department at the time I assumed the Chairmanship. Others arrived when I did or later.

A.B.R. (Alan) Thomson. Among the most productive researchers in the Department, he established a world-wide scientific and educational reputation. Notwithstading numerous

honours and editorships, Allan remained a highly committed and energetic teacher for undergraduates, postgraduates and graduates alike. He managed to be a popular consultant and developed into a *quadruple threat* as a much-involved administrator both in and out of the Department. His contributions to the Education and Research Committees and in long range planning were all substantial as well. He took the helm of the Division of Gastroenterology in 1985. His interactions with Nutrition were of mutual benefit to our faculty and to the Department of Foods and Nutrition in the Faculty of Home Economics.

D.L.J. (Lorne) Tyrrell. Based on outstanding performance in all academic phases of activity both in Medicine and in Biochemistry he had a meteoric rise academically. Among the most acclaimed and popular teachers in both departments, his renown in molecular virology led to administrative advances as well. In 1984 he took over the Division of Infectious Diseases and soon thereafter the newly-merged Department of Microbiology and Infectious Diseases. His specific Departmental administrative contributions were many, especially in the field of education. He was particularly productive in the later stages of long term planning and educational reforms.

C. (Chris) Von Westarp was a well-rounded academic endocrinologist with special interest and activity in thyroidology. He participated in the Clinical Practice Committee. His personal decision to leave academia for specialist practice in Victoria was a major loss to the Department.

J.R. (Jim) Hill, cross-appointed from the Department of Laboratory Medicine, capably directed the Division of Hematology from 1977 until 1981, and played a valuable role in the interactions of his specialty among the Department of Medicine, Cross Cancer

Institute and the Department of Laboratory Medicine of the University Hospitals.

M.J. Mant joined the Department from the Department of Laboratory Medicine and acted as Director of the Division of Hematology in 1975 and 1976. He was productive in academic hematology and hematologic oncology. He participated in clinical practice affairs of the Department and often voiced valuable dissenting views during Departmental discussions.

R.J. Bailey, a gastroenterologist and hepatologist at the Royal Alexandra Hospital, was a vocal and effective leader in the Department's affairs, principally as Chief of Medicine at the Royal Alexandra Hospital.

N.E. (Neil) Brown An academic pulmonologist, he coordinated Departmental Grand Rounds as a successor to Buzz Edwards.

Paul Davis was highly productive in all phases of academic activity and rheumatology. He was active in the Clinical Practice Committee which he later chaired. Eventually he took over direction of the Rheumatology Division from Tony Russell.

S.F.P. (Paul) Man rapidly achieved wide recognition in academic pulmonology. He was a quiet, productive and effective academic. He served on the Research Committee from 1979 on, and chaired the key committee on Graduate Education as it was formed in 1984. He was instrumental in contributing to the major success of the Department's Graduate Education planning and its achievements.

A.R. (Bob) Turner, an accomplished hematologist/oncologist was active in the Education Committee and was a major voice in Departmental planning efforts. In addition to his research, teaching and practice efforts, he was a leader in the Red Cross and became

Director of the Division of Hematology in 1984.

C.T. (Tissa) Kappagoda, a cardiologist and cardiac physiologist of international renown, was the first director of cardiac rehabilitation. On the Research Committee from 1979 he became its Chairman in 1981-1982. He made major contributions to the Department until his departure to the University of California at Davis.

E.H. Schloss had a career in Pathology before he trained in Dermatology and eventually became Director of that Division, succeeding Jack Brown.

K.G. (Ken) Warren made his name in multiple sclerosis practice and research as well as a respected all-round academic neurologist.

R.V. (Ray) Rajotte had a joint appointment in Medicine and Surgery. His research in cryobiology and transplantation had many facets but principally focused on pancreatic islet transplantation, a field in which he continues to be a major, well-recognized, world leader. He continued to participate in the Division of Endocrinology and Metabolism despite the *hands on* nature of his extensive research efforts and his world-wide commitments.

A.H.G. (Sandy) Patterson, an academic oncologist researched and taught actively and was involved in resident and undergraduate education activities of the Department.

W.P. Klinke, a cardiologist at the Royal Alexandra Hospital, assumed an increasingly important role in his Hospital's cardiologic activities and his own research.

M.G. Nutting, an internist at the Misericordia Hospital, was also involved in Oncology and became Chief of the Department of Medicine at his Hospital.

B.I. (Bodh) Jugdutt in Cardiology proved to be a most accomplished researcher. He

has been the recipient of numerous awards and recognitions, among the most important were his AHFMR Scholarship and eventual status as Medical Scientist.

A.D. (Tony) Morrison a diabetologist/endocrinologist was briefly active in the Metabolic Centre but by 1982 left to the University of Florida in Tampa eventually to re-settle at the University of British Columbia in Vancouver.

J.C. (Chuck) Morrison was a most fortunate acquisition to the Department's administrative staff. He was recruited on the principle of relieving the clinical and scientific staff of as much administrative burden as possible, and thereby facilitating their concentration on clinical and scientific matters, and of course, teaching. He came with special educational administrative experience both academically and in practice at the University of Calgary. His appointment proved to be a sound move with lasting benefits. He was initially Executive Assistant for Education. To that was added Research. Chuck acted with increasing independence in exactly the role foreseen for him on the Education, Research and Long-Range Planning Committees. He had a major role in the Department's Self Study for the PACCR. The compilation of academic records and the annual reports were outstandingly well handled through his direct input. His interest, energy and analytical approach, not to mention his considerable communication skills, provided great help for the Department's administrative activities. Principally through his efforts, the organizational growth and development of the Department, with clear job descriptions of tasks, positions and administrative units, satisfied and impressed all concerned. It was indeed a logical extension of Chuck's activities and due recognition of his accomplishments that he became Director of the Division of Administrative Services during my successor's term.

D.W. Morrish, an endocrinologist, with additional oncological expertise and activities as well, appropriately made his mark and was involved in the ethics committee and later in Practice Plan activities in addition to fine all-round academic performance.

W.A. (Bill) McBlain, an endocrinologist, was in charge of the steroid receptor laboratory. He was an excellent teacher and an enthusiastic link between basic and clinical teaching and research efforts. Bill was active early in the Research Committee and later in the Graduate Education Committee which he eventually chaired with considerable success.

S.E. (Susan) Kaufman, a physiologist and heritage scholar, had joint appointments in the Divisions of Cardiology and Endocrinology.

A.L.A (Tony) Fields had a well-deserved, rapid academic rise within the Department of Medicine at the W.W. Cross Cancer Institute replacing initially Alex MacPherson and later Neil MacDonald in their respective administrative roles. A committed humanistic teacher and a fine researcher, he kept up his academic strengths even while ever more involved in administration. He served on the Education Committee, later specifically on the Undergraduate Education Committee and from 1985 on in the role of Chief of Medicine at the Cross Cancer Institute as well.

P.M. Venner in Medical Oncology was active in Internal Medicine as well and played a major role on the Ethics Committee.

T.W. (Tom) Noseworthy developed major academic strengths in Critical Care Medicine at the Royal Alexandra Hospital and also city-wide in all of the hospitals. He was also an outstanding teacher in Internal Medicine. He succeeded Garner King in directing

the free-standing division of Critical Care Medicine in the Faculty. From there he went on to become Vice-President (Medical) and eventually President of the Royal Alexandra Hospitals.

Eugene Kretzul has been an active teacher of Internal Medicine at the Misericordia Hospital, active in the Department's Resident Training Committee as well as in his in-hospital's educational committees.

J.R. Burton, a welcome acquisition to the Division of Cardiology, took an early lead in the performance and documentation of invasive cardiac activities in the field of coronary heart disease.

Dorcas Fulton has been an academic neurologist in medical oncology and shared appointments between the Cross Cancer Institute and the University Hospitals.

J.W. Warnica performed impressively as the Coronary Care Intensive Care Unit Director from 1981 until his departure to the University of Calgary in 1985. He was on the Ethics Committee.

R.A. (Ray) Ulan returned from the University of Western Ontario to Alberta in the Division of Immunology and Nephrology. He eventually became acting director of that division in 1985. He was initially on the Education Committee but later chaired the Undergraduate Education Committee from 1984 on, with a major role in the undergraduate education reforms which were developed.

L.J. (Lil) Miedzinski was in Infectious Diseases, a division which she eventually directed. She joined the Clinical Practice Committee in 1983.

Jody Ginsberg, was an endocrinologist, thyroidologist who soon made his mark in

research and teaching as well as in administration, as he succeeded Peter Crockford in the direction of the division of Endocrinology and Metabolism. He had a major impact on the Undergraduate Education Committee.

E.A. (Eddy) Ryan was a clinical investigator of AHFMR with solid credentials and outstanding performance in diabetes research. He directed the Metabolic Day Care Centre and was Assistant Director of the Muttart DRTC.

F.X. Witkowski joined the Cardiology Division as a Heritage Scholar. His impressively innovative research productivity was logically coupled with his sound performance on the Research Committee which he eventually chaired.

A.A.C (Albert) Yeung joined the Division of General Internal Medicine as well as the Department of Pharmacology. This was the culmination of an all-too-long search for academic general internist, who was also a clinical pharmacologist.

R.N. Fedorak initiated an impressive academic career in the Division of Gastroenterology in 1986. He sustained his initial performance well and has continued as a Heritage Scholar.

E.L. (Ellen) Toth in the Division of Endocrinology and Metabolism, a diabetologist and clinical researcher, was an impressive performer in Resident Training. In later years she was to become Resident Training Director.

I.A. (Iain) Ferguson joined the Division of Immunology and Nephrology and also accepted the challenge of the GFT position at the Royal Alexandra Hospital in 1986, in charge of Clinical Education, replacing Alan Gilbert.

CONCLUSION

Serving the Department of Medicine at the University of Alberta as Chairman has been *the* great privilege of my professional life. I am proud to claim for and on behalf of the Staff of the Department the following accomplishments during the years 1975-1986:

- Growth of Department
- Building on strengths
- Sustainment of humanistic and clinical standards of excellence, while meeting the challenge of basic science-molecular biology requirements in light of scientific progress, for educational and research functions and for funding by extramural funding sources
- Reinforcement of collegial interrelationships both within the Faculty among clinical and basic science departments, as well as among the staffs of the University of Alberta Hospital and Affiliated Teaching Hospitals
- Development of a strong and capable departmental administrative core to provide adequate job-and-task-descriptions to facilitate function so that academic staff may teach, do research, and practice, while administrators administer
- The foregoing with a proviso that it was clearly understood that academic consensus and not an over-centralized administration determines policies
- Although the goal of a Departmental Practice Plan was not attained, the basis for success of such a plan was prepared
- All of the foregoing prepared a well-organized, mature Department to face the times of restraint in the latter 1980's and the potentially even further encroachment of Government on funding of academia, with which the final decade of the Twentieth Century began.

Through demonstrated excellence in practice, teaching and research the Department was ready for these challenges. The seven years which have passed since July of 1986 document the fine continued performance of the Department and encourage faith in its bright future.

ACKNOWLEDGEMENTS

I wish to thank the following:

Mrs. Susan DeMartini for data research, assembly and manuscript preparation.

Mr. J. Charles Morrison for data and document searches and assistance with the graphic and tabular displays (finalized by Mrs. DeMartini) and my wife Gwen for editorial review.

Their expert help and advice made this report possible.

APPENDICES

The accounts written by the Department of Medicine's chairmen which preceded mine included many, if not all the names of the staff and other key personnel. By 1975, but especially in the years which followed, the number of individuals and their activities worthy of recording warrant the use of lists to tell the Department's story. Hence these appendices.* They contain:

I. Academic Staff Membership in 1974 and Subsequent Yearly Changes

II. Committee Memberships

III. Chiefs of Medicine at the Affiliated Teaching Hospitals

IV. Divisional Directors

V. Chief Medical Residents

VI. Recognition of Teaching Excellence

VII. Honours and Awards

VIII. Compensation of Part-Time Staff

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*Appendix VIII is not a list, but detailed information on Compensation of Part-time Staff.

APPENDIX I

ACADEMIC STAFF MEMBERSHIP IN 1974 AND CHANGES YEAR-BY-YEAR

1974

Prof and Acting Chairman
SPROULE, B.J., M.D. (Alberta '51)

Professors
CROCKFORD, P.M., M.D. (Alberta '59)
DOSSETOR, J.B., MBChB (Oxford '51); Ph.D. (McGill '61)
FRASER, R.S., M.D. (Alberta '46)
GILBERT, J.A.L., MBChB (Edinburgh '41)
MacDONALD, N., M.D.CM (McGill '59)
MONCKTON, G., M.D. (London '48)
NIHEI, T., D.Sc. (Tokyo '57)
ROSSALL, R.E., MBChB (Leeds '50), M.D. (Leeds '58)
WILSON, D.R., M.D. (Toronto '59)

Associate Professors
ANHOLT, L.M., M.D. (Alberta '58)
BAND, P.R., M.D. (Montreal '62)
BASUALDO, C.A.E., M.D. (Cordoba '58)
BRUCHOVSKY, N., M.D. (Toronto '61), Ph.D. (Toronto, '66)
FAWCETT, D.M., M.D. (Alberta '59), Ph.D. (McMaster '55)
GOLDSAND, G., M.D. (Alberta '59)
HARLEY, C., M.D. (Alberta '65)
HIGGINS, M.R., MBChB (Edinburgh '61)
KING, E.G., M.D. (Alberta '63)
LEE, S.J.K., M.D. (Seoul, Korea '57)
McLEAN, D.R., M.D. (Manitoba '60)
McPHERSON, T.A., M.D. (Alberta '62); Ph.D. (Melbourne '68)
PERCY, J.S., MBBS (Durham '61); M.D. (Newcastle '66)
RUSSELL, A.S., MBChB (Cambridge '63); M.A. (Cambridge '64)
TAYLOR, R.F., M.D. (McGill '50)
WEINSTEIN, W.M., M.D. (Queens, '64)

Assistant Professors
BUCKLE, F.G., M.D. (Saskatchewan '67)
HARAPHONGSE, M., M.D. (Mahidol '64)
RABIN, H.R., M.D. (Wes '65)

Clinical Professors
DVORKIN, J., M.D.. (Alberta '43)
ELLIOTT, J.F., M.D. (Alberta '36)
WHITING, R.H., M.D. (McGill '42)

Associate Clinical Professors
BELL, D.M., M.D. (Alberta '44)
BLACK, W.R., M.D. (Alberta '56)
BLAIN, G.J.G., M.D. (Alberta '59)
BROWN, G.D., M.D. (Alberta '48)
EDWARDS, A.M., M.D. (Alberta '50)
EIDEM, R.N., M.D. (Alberta '55)
JACOBS, H., MBBCh (Cambridge '53); MMed (Med) (Capetown '58)
KIDD, E.G., M.D. (Alberta '45)
RENTIERS, P.L., M.D. (Alberta '42)
RYAN, J.M., M.D. (Dalhousie '50)
SHERBANIUK, R.W., M.D. (Alberta '52)
SILVERBERG, D.S., M.D. (Manitoba '62)
SPRAGUE, J.H., M.D. (Alberta '62)
WENSEL, R.H., M.D. (Alberta '56)
WILLIAMS, J.V., MBChB (Cantab '55); M.D. (Cantab '63)

Assistant Clinical Professors
AARON, T.H., M.D. (Alberta '42)
BROWN, J., M.D. (Alberta '60)
COGLAN, R.B., M.D. (Alberta '54)
DOUGALL, R.H., M.D. (Alberta '53)
HERBERT, F.A., M.D. (Manitoba '55)
HOPKYNS, J.C.W., MBChB (Middlesex '40)
IRVING, D.W., M.D. (Alberta '57)
JONES, R.L., M.S. (Marquette '69); PhD (Marquette '70)
JUDGE, D.L., M.D. (Alberta '51)
KORNELL, S., MBBCh (Witwatersrand, S. Africa '51)
MacDONALD, F.G., M.D. (Alberta '61)
MENDES, P.C., M.D. (McGill '59)
PRESWICK, G., MBBS (Sydney, '55)
RAMSEY, C.G., M.D.C.M. (McGill '48)
SARTOR, V.E., M.D. (Alberta '61)
ST. CLAIR, W.R., MBChB (Edinburgh '46)
STEFANYK, H., M.D. (Alberta '56)
TOUPIN, H.M., M.D. (Alberta '49)
VARVIS, C.J., M.D. (Alberta '53)
WEISZ, S., M.D. (Alberta '56)
YOUNG, M.K., M.D. (Alberta '40)

Honorary Professor
HUNKA, S., BEd MEd (Alberta '57), Ph.D. (Illinois '61)

Honorary Assistant Clinical Professors
FANNING, E.A., M.D. (Western Ontario ' 63)
FIDDES, G.W.J., M.D., (Queens '40)

Clinical Lecturers
BELL, G.I., M.D. (Alberta '40)
CAIRNS, A., M.D. (Alberta '45)
CAMPBELL, V.J., M.D. (Alberta '53)
DONNELLY, R., M.D. (Alberta '66)
GOODHART, J.M., MBBS (Newcastle '61)
LEFEBVRE, R.E., M.D. (Alberta '65)
McCAFFERY, J.T., M.D. (Alberta '62)
ROMANOWSKI, E., M.D. (Poznan, Poland '37)
TAKATS, L.N., M.D. (Alberta '63)
TALIBI, T., M.D. (Istanbul '57)

Honorary Clinical Lecturer
KHALIQ, A, MBBS (Karachi, Pakistan '59)

Honorary Lecturers
GREENHILL, S.E., M.D. (Toronto '44)
SEREDA, M.M., M.D. (Alberta '36)

Clinical Instructors
BETTCHER, K.B., MBBS (Adelaide '61)
BROOKS, C.H., M.D. (Alberta '65)
DANIAL, B.H., MBBS (Osmania, India '61)
HARDIN, I., M.D. (Alberta '43)
JAMPOLSKY, N.A., M.D. (Alberta '56)
MUTTITT, E.L., M.D. (Manitoba '49)
SEREDA, A.W., M.D. (Alberta '64)
TE, L.D., M.D. (Santo Tomas '56)
WILSON, A.F., M.D. (Alberta '64)

Honorary Clinical Instructors
SCHAEFER, O., M.D. (Heidelberg, Germany '45)
TALPASH, O.S., M.D. (Saskatchewan ' 63)
TUSZ, D.J., M.D. (Saskatchewan '68)

Professor Emeritus
SCOTT, J.W., M.D. (McGill '21)

Emeritus Associate Professor
SPRAGUE, P.H., M.D. (Alberta '27)

1975

Appointments

MOLNAR, George Dempster, M.D. (Alberta '51), Ph.D. (Minn. '56), Professor, Endocrinology and Metabolism, Chairman, Department of Medicine

THOMSON, Alan Bryan Robert, M.D. (Queen's '67), Ph.D. (Queens '71), Assistant Professor, Gastroenterology

TYRRELL, D.L.J., M.D. (Alberta '68), Ph.D. (Queen's 72), Assistant Professor, Infectious Diseases

VON WESTARP, Christian, M.D. (Dalhousie '70), Assistant Professor, Endocrinology & Metabolism

Cross Appointments

BELCH, A.,, M.D. (Toronto '70), Assistant Professor, Medical Oncology & Clinical Hematology

HILL, J.R., M.D. (Saskatchewan '59), Consulting, Clinical Hematology, Department of Laboratory Medicine

MANT, M.J., MBChB (Otago '64), Associate Professor, Clinical Hematology, Department of Laboratory Medicine

Departures

BLAIN, G.J.G., Associate Clinical Professor, Neurology, to University of Sherbrooke

BUCKLE, F.G., Assistant Professor, to private practice in Calgary

Retirements

RENTIERS, P.L., Associate Clinical Professor, Dermatology

1976

Appointments

BAILEY, R.J., M.D. (Ottawa '68), Assistant Clinical Professor, Gastroenterology, Royal Alexandra Hospital

BALSYS, A.J., M.D. (Toronto '68), Assistant Clinical Professor, Pulmonary Diseases and Intensive Care

BROWN, N.E., M.D. (Toronto '71), Assistant Professor, Pulmonary Diseases

DAVIS, P., MBChB (Bristol '69), Assistant Clinical Professor, Rheumatology

KOVITHAVONGS, T., M.D. (Bangkok '65), Ph.D. (Alberta '76); Assistant Clinical Professor, Nephrology & Immunology

LIAO, J.Y., MBBS (Malaysia '70), Clinical Instructor, Dermatology

MAN, S.F.P., M.D. (Alberta '70), Assistant Professor, Pulmonary Diseases

MARYNOWSKI, B., M.D. (Alberta '63) Clinical Instructor, Neurology, EGH, MH, RAH

PAZDERKA, F., M.Sc. (Moscow '59), Ph.D. (Moscow '65), Assistant Professor, Nephrology & Immunology

STARREVELD, E. M.D. (Amsterdam '64), Clinical Instructor, Neurology, EGH, MH, RAH

Cross Appointments

FINER, N.N., M.D. (Toronto '68), Honorary Associate Professor, Pulmonary Medicine, Pediatrics

HARLEY, F., M.D., (Western Ontario '65) Honarary Assistant Professor, Nephrology, Pediatrics

LARKE, R.P.B., M.D. (Queens '60), Honorary Professor, Infectious Diseases, Provincial Lab and Microbiology

SHUTT, H.K., M.D. (Alberta '63), Associate Clinical Professor, Neurology, Ophthalmology

Departures

BAND, P.R., Associate Professor, Medical Oncology to University of Montreal

BROOKS, C.H., Clinical Instructor, Cardiology to Phoenix, AZ, USA

Death

DVORKIN, J., Clinical Professor, Cardiology

1977

Appointments
BONGARD, H., M.D., (Qns '71), Assistant Clinical Professor, Pulmonary Medicine
JOHNY, K.V., M.D. (Kerala '65), Visiting Associate Professor, Nephrology
TURNER, A.R., M.D.C.M., (McGill '72), Assistant Professor, Medical Oncology

Cross Appointments
GORDON, P.A., MBChB (Capetown '65), Assistant Clinical Professor, Clinical Haematology, Lab Medicine
WADSWORTH, L.D., MBChB (Manchester '66), Assistant Clinical Professor, Clinical Haematology, Lab Medicine
NIGRIN, J., M.D. (Charles '66), Clinical Instructor, Neurology, Microbiology
SCOTT, J.Z., MBChB (Birmingham '62), Assistant Professor, Endocrinology & Metabolism, Obstetrics & Gynaecology
ORFORD, R.R., MDCM (McGill '71), Assistant Clinical Professor, General Internal Medicine, Community Medicine
WHITE, F.M.M., M.D. (McGill '69), Honorary Associate Clinical Professor, Infectious Diseases

Departures
SILVERBERG, D.S., Associate Clinical Professor, Cardiology, to Israel

Retirement
FIDDES, G.W.J., Honarary Assistant Clinical Professor, Pulmonary Medicine

1978

Appointments

HANNON, J.L., M.D. (Alberta '71) Assistant Clinical Professor, Clinical Hematology
KAPPAGODA, C.T., MBBS (Ceylon, SriLanka '65), Ph.D. (University of Leeds, UK, 1972), Associate Professor, Cardiology
SCHLOSS, E.H., M.D., (Alberta '63), Assistant Clinical Professor, Dermatology
BELLAMY, L.A., M.D., (Alberta '73), Clinical Instructor, Physical Medicine & Rehabilitation
WARREN, K.G., M.D., (Western Ontario '72), Assistant Professor, Neurology
CONNOLLY, T., MBBCh, (Ireland '70), Assistant Clinical Professor, Pulmonary Medicine
CLELAND, L., MBBS (Adelaide '70), Visiting Lecturer, Rheumatology
BUTLER, M.J. MBBS (Otago '68), Visiting Lecturer, Rheumatology
RAJOTTE, R.V., Ph.D. (Alberta '75), Research Associate, Endocrinology & Metabolism
SHAW, A.R.E., Ph.D. (Southampton '69), Assistant Professor, Medical Oncology
PATERSON, A.H.G., MBChB, M.D. (Edinburgh '69), Assistant Professor, Medical Oncology
KLINKE, W.P., M.D., (Alberta '72), Clinical Instructor, Cardiology (RAH)
KUBAC, G., M.D., (Charles '58), Clinical Instructor, Cardiology (RAH)
NUTTING, M.G., MBBS (London '69), Clinical Instructor, General Internal Medicine & Medical Oncology (Misericordia)
ROBERTS, R.N., M.D., (Alberta '70) Clinical Instructor, General Internal Medicine (RAH)

Cross Appointments

TURC, J.M., M.D., (Dijon '71) Associate Clinical Professor, Hematology, Lab Medicine
McTAGGART, R.A., M.C. (Alberta '70), Assistant Clinical Professor, Pulmonary Medicine, Intensive Care & Anesthesia, RAH
AARON, T.H., M.D. (Alberta '42), Associate Clinical Professor, Immunology & Nephrology, General Internal Medicine
PETRIK, P., MB MD (Karlova '63), from Pathology

Departures

BONGARD, H., Assistant Clinical Professor, Pulmonary Medicine
NIGRIN, J., Clinical Instructor, Neurology
RABIN, H.R., Associate Professor, Infectious Diseases, to Head Division of Infectious Diseases at University of Calgary
SEREDA, A.W., Clinical Instructor, Neurology
SCHULD, R.L., Clinical Instructor, Cardiology, to Lethbridge
WADSWORTH, L.D., Assistant Clinical Professor, Hematology

Retirement

WILSON, D.R., Professor, Endocrinology (became Professor Emeritus status in 79/80)

1979

Appointments

GRACE, M.G.A., Ph.D., (Harvard '72), - Honorary Associate Professor
JUGDUTT, B.I., MBChB, (Glasgow '70), Assistant Professor, Cardiology
MAN, G.C., MBBS, (Hong Kong '72), Clinical, Lecturer, Pulmonary Medicine
ROMANOWSKI, B., M.D., (Alberta '73), Clinical Lecturer, Infectious Diseases
TODORUK, D.N., M.D., (Alberta '71), Clinical Lecturer, Gastroenterology (Charles Camsell)
WONG, K., Ph.D. (Alberta '76), Assistant Professor - Rheumatology
CAMPBELL, D.A., M.D., (Queen's '70), Clinical Instructor, General Internal Medicine, Charles Camsell Hospital
GREENWOOD, P.V., MBChB, (Leeds '72), Assistant Professor, Cardiology, Misericordia
MILLAN, M.S., M.D. (Alberta '72), Clinical Instructor, Gastroenterology, Misericordia
LEE, T.K., MBBS, (Singapore '71), Clinical Instructor, Pulmonary Medicine, Edmonton General
ROBERTSON, C.C., MBChB (Oxford '71), Asssistant Clinical Professor, General Internal Medicine, RAH
SWITZER, C.M., M.D., (Alberta '74), Clinical Instructor, Gastroenterology, General Hospital
PATERSON, A.H.G., MBChB, M.D. (Edinburgh '69), Assistant Professor, Medical Oncology

Cross Appointments
BRUNTON, J.S., MDCM (McGill '72), Assistant Professor, Infectious Diseases, Medical Bacteriology

Departures
BALSYS, A.J., Assistant Clinical Professor, Pulmonary Medicine to Director, ICU, Ottawa Civic Hospital
BRUCHOVSKY, N., Professor, Endocrinology, Chairman, Endocrine Dept, B.C. Cancer Unit
DONNELLY, R., Assistant Clinical Professor, General Internal Medicine, to Red Deer
DOUGALL, R.H., Assistant Clinical Professor, General Internal Medicine, to Claresholm
RABIN, H.R., Associate Professor, Infectious Diseases, to Head of Infectious Diseases Section, Univ. of Calgary
RENNIE, P.S., Assistant Professor, Endocrinology, to B.C. Cancer Institute *(came in 77/78)*
WEINSTEIN, W.M., Professor, Gastroenterology, to UCLA

Retirement
ROMANOWSKI, E., Associate Clinical Professor Emeritus, General Internal Medicine

Assignment Completed (Visiting Professor)
BUCKNALL, R.C. - Rheumatology (Visiting Assistant Professor)
CLELAND, L.G. - Rheumatology (Visiting Lecturer)
JOHNY, K.V. - Nephrology (Visiting Associate Professor)

1980

Appointments

HOLT, S., MBChB, (Liverpool, England '72), Assistant Professor, Gastroenterology
MARIEN, G.J.R., M.D., (Alberta '69), Assistant Professor, Infectious Diseases
MONTGOMERY, P.R., M.D., (Manitoba '74), Assistant Professor, General Interal Medicine
MORRISON, A.D., M.D., (McGill '63), Associate Professor, Endocrinology,
WARNICA, J.M., M.D., (Manitoba '66), Associate Professor, Cardiology
MORRISH, D.W., M.D., (Alberta '70); Ph.D. (California '81), Assistant Professor, Endocrinology
McBLAIN, W.A., Ph.D. (Alberta '76), Assistant Professor, Endocrinology
KAUFMAN, S.E., Ph.D. (British Columbia '71), Assistant Professor, Cardiology/Endocrinology
SWITZER, C.M., M.D. (Alberta '74), Clinical Instructor, Gastroenterology
WATERS, J.R., M.D. (Manitoba '66), Associate Clinical Professor, Infectious Diseases
NG, K.C., MBBS (Singapore '70), Visiting Lecturer, Rheumatology
JAKOBISIAK, M., M.D. (Warsaw '68), Visiting Assistant Professor, Immunology/Nephrology
FIELDS, A.L.A., M.D. (Alberta '74), Assistant Professor - Medical Oncology (CCI)
VENNER, P.M., M.D., (Alberta '73), Assistant Professor, Medical Oncology (CCI)
NOSEWORTHY, T.W., M.D. (Memorial '73), Assistant Professor, Pulmonary & Intensive Care (RAH)
KRETZUL, E., M.D., (Alberta '73), Clinical Instructor, General Internal Medicine (MH)

Cross Appointments
GREENHILL, S., M.D. (Toronto '44) Honorary Professor, General Internal Medicine (Dept. of Community of Medicine)

Departures

Assignment Completed
KARIM, F., Visiting Scientist, Cardiology

Other
CONNOLLY, T.P. - Assistant Professor, Pulmonary, to Victoria, B.C.
PITTOKOPITIS, K., Clinical Lecturer, Pulmonary, to USA
WHITE, F.M., Associate Clinical Professor, Infectious Diseases, to Victoria, B.C.

Retirement
YOUNG, M.K. - Assistant Clinical Professor Emeritus, General Internal Medicine (RAH)

1981

Appointments

BURTON, J.R., M.D., (Toronto '66), Associate Professor(Clinical Medicine), Cardiology
DICKOUT, W.J., M.D., (Alberta '75), Assistant Professor(Clinical Medicine), Pulmonary Medicine
FULTON, D, M.D., (Toronto '72), Assistant Professor, Neurology and Medical Oncology
HOLT, S., MBChB, (Liverpool, England '72), Assistant Professor, Gastroenterology
WARNICA, J.W., M.D., (Manitoba '66), Associate Professor - Cardiology, Director of CICU
St. J. HAMMOND, P., MBBS (London '70), D. Phil (Oxford 78), Assistant Professor, Immunology/Nephrology

Cross Appointments

CUMMING, David, Honorary Assistant Professor, Endocrinology & Metabolism, Obstetrics & Gynaecology
VESTRUP, J.A., M.D., (UBC '73), Assistant Professor, Pulmonary Medicine, Surgery

Departures

BELL, D., Honorary Associate Professor, General Internal Medicine, to Victoria B.C.
BRUNTON, J.L., Assistant Professor, Infectious Diseases, moved to University of Toronto
HIGGINS, M.R., Associate Professor, Nephrology & Clinical Immunology, to East Virginia Medical School, Richmond, VA, USA

Retirement

ELLIOTT, J.F., Distinguished Clinical Professor, General Internal Medicine

Death

YOUNG, M.K., Assistant Clinical Professor Emeritus, General Internal Medicine, RAH

1982

Appointments
ULAN, R.A., M.D. (Alberta '61), Professor, Immunology & Nephrology
KRANTZ, M., Ph.D. (Berkley '71), Associate Research Professor, Medical Oncology
LEUNG, W.-C., Ph.D. (Baylor '74), Associate Professor (Research), Infectious Diseases
McLEOD, L.E., M.D., (Alberta '51), Honorary Professor, Endocrinology
MIEDZINSKI, L.J., M.D., (Alberta '76), Assistant Professor, Infectious Diseases
SHUSTACK, A., MDCM, (McGill '75), Clinical Lecturer, Pulmonary Medicine (RAH)
TAI, C., MBBS (Singapore, '69), Clinical Instructor, Neurology (RAH)

Cross Appointments
FERGUSON, J.P., M.D. (Alberta '75), Clinical Instructor, Gastroenterology, Lab Medicine
BRIEN, W., M.D. (UWO '77), Clinical Hematology joint appointment with Lab Medicine

Departures
DICKOUT, W.J., Assistant Professor(Clinical Medicine), Pulmonary Medicine
HANNON, J.L., Assistant Clinical Professor, Clinical Hematology, to California
HILL, J.R., Clinical Professor and Acting Director, Division of Hematology
MORRISON, A.D., Associate Professor, Endocrinology, to Tampa, Florida, USA
VESTRUP, J.A., Assistant Professor, Pulmonary Medicine, (cross appt. with Surgery)
St. John HAMMOND, P., Assistant Professor, Immunology & Nephrology

Death
STEFANYK, H., Associate Clinical Professor, Gastroenterology & Internal Medicine

1983

Appointments

CHERRY, R.D., M.D., (Saskatchewan '75), Assistant Clinical Professor, Gastroenterology
ELLEKER, M.G., M.D., (Alberta '75), Assistant Clinical Professor, Neurology
GINSBERG, J., M.D., (Toronto '74), Assistant Professor, Endocrinology & Metabolism
HULBERT, W.C., M.D. (W.Wash '73), Associate Professor (Research), Pulmonary
PREIKSAITIS, J.K., M.D. (McMaster '76), Assistant Professor (Research), Infectious Diseases
RYAN, E.A., M.D. (Dublin '75), Assistant Professor, Endocrinology & Metabolism
YORK, E.L., M.D., (Witwatersrand, South Africa '68), Assistant Professor (Internal Medicine), Pulmonary
DASGUPTA, M., M.D., (Calcutta '60), Assistant Professor, Immunology and Nephrology
MALOWANY, L.E.R., M.D., (Alberta '78), General Internal Medicine - RAH
VAN DEN BERG, L., MBChB (Pretoria '75), General Internal Medicine - Charles Camsell Hospital
HANNON, J., M.D., (Alberta '71) - Clinical Hematology - Blood Transfusion Service
HAMILTON, S., M.D.C.M. (McGill '77), - Pulmonary - cross appointment in Critical Care

Cross Appointments

MANNONI, P., M.D. (Paris '60), Honorary Associate Professor, Clinical Hematology (Pathology)

Departures

FRIMAN, C.E. - Visiting Associate Professor (Rheumatology) returned to Finland
HOLT, S., Assistant Professor, Gastroenterology, to Saskatoon
REWA, G., Assistant Clinical Professor, Cardiology, to Toronto
KUBAC, G, Clinical Instructor, Cardiology, RAH (resigned)

1984

Appointments

ALLAN, S.J., M.D., (Alberta '79), Clinical Lecturer, General Internal Medicine
CHIN, W.D.N., MBBCh (Witwatersrand '73), Pulmonary Medicine, Assistant Professor
GRYNOCH, J.R., M.D. (Toronto '73), Clinical Instructor, Immunology and Nephrology
HUMEN, D.P., M.D., (Alberta '75), Assistant Professor, Cardiology
JANOWSKA-WIECZOREK, A., M.D. (Warsaw '69), Ph.D. (Warsaw '77), Assistant Research Professor - Clinical Hematology
LAKHANI, Z., MBChB, Clinical Lecturer, General Internal Medicine, Charles Camsell Hospital
MacLEAN, G.D., MBChB (Auckland '74), Assistant Professor (Research), Medical Oncology
ROSTAMI, A. M.D. (Isfahan '70) - Visiting Associate Professor - Cardiology
WILSON, Douglas R., M.D., (Toronto '59), Dean of Medicine, Professor, Immunology and Nephrology
WITKOWSKI, F.X., M.D., (Washington '78), Assistant Professor, Cardiology
YAO, L.C.H., M.D., (Manitoba '78), Assistant Professor, Cardiology (Internal Medicine)

Cross Appointments

BASU, T.K., MSc (London '68), Ph.D. (Surrey '71), Honorary Professor (Medicine), Faculty of Home Economics
BRETSCHER, P.A., Ph.D. (Cantab '68), Associate Professor, Rheumatology (from Immunology) as Alberta Cancer Board-supported Associate Professor
CLANDININ, M.T., Ph.D. (Alberta '73) - Professor, Gastroenterology, (Faculty of Home Economics)
GUIDOTTI, T.L., M.D. (UCSD '75), Ph.D. (Alberta '73) - Honorary Professor - Pulmonary Medicine (cross appointed from Department of Health Service Administration & Community Medicine)

Retired

SCHAEFER, O., Honorary Professor, General Internal Medicine
NIHEI, T., Professor, Neurology

1985

Appointments

ABDI, E.A., MBBS (Adelaide '72), Medical Oncology, Lecturer
FITZGERALD, A.A., M.D., (Alberta '76), Rheumatology, Assistant Clinical Professor
KING, M., Ph.D. (McGill '73), Associate Research Professor, Pulmonary
MAHACHAI, V., M.D. (Chulalongkorn, Thailand '76), Assistant Professor, Gastroenterology
MALOWANY, L.E.R., M.D., (Alberta '78), General Internal Medicine, Clinical Instructor
O'BRIEN, D.W., Ph.D. (Oregon '78), Endocrinology, Lecturer
TAYLOR, G.D., M.D., (Saskatchewan '77), Infectious Diseases, Lecturer
TYMCHAK, W.J., M.D., (Alberta '79), Assistant Professor, Cardiology,
VOTH, A.J., M.D. (Sasktachewan '66), Clinical Lecturer, General Internal Medicine
YEUNG, A.A.C., MBChB (Glasgow '74), M.D. (Glasgow '86), General Internal Medicine, Assistant Professor (also in Pharmacol)

Departures

McPHERSON, T.A., Professor, Medical Oncology, to Deputy Minister Department, Hospital Medical Care
ROSTAMI, A., Associate Visiting Professor, Cardiology, returned to Iran
VON WESTARP, C.H., Associate Professor, Endocrinology, to private practice in Victoria
WARNICA, J.W., Associate Professor, Cardiology, to University of Calgary

Retirement

KIDD, E.G., Clinical Professor, Rheumatology
MONCKTON, G., Professor, Neurology

Death

TOUPIN, H.M., Associate Clinical Professor, Neurology

1986

Appointments
FEDORAK, R.N., M.D., (Alberta '78), Assistant Professor, Gastroenterology
FERGUSON, I.A., M.D., (Manitoba '70), Associate Professor, Immunology/Nephrology
FINEGOOD, D.T., Ph.D., (USC '84), Endocrinology/Metabolism
JIVRAJ, K.T., MBBS (London '80), Lecturer, Pulmonary Medicine
ROGERS, M.B., M.D., (Wes '71), Clinical Lecturer, Dermatology
SHEEHAN, G., MBChB (Ireland '79), Infectious Diseases (dual appt. with Intensive Care Medicine)
STOLLERY, D.E., M.D., (Alberta '79), Assistant Clinical Professor, Pulmonary Medicine
TOTH, E.L., M.D., (Buenos Aires '78), Assistant Professor, Endocrinology/Metabolism
TRAYHURN, P., Ph.D. (Oxford '72), Professor, Gastroenterology
WARREN, S.A., Ph.D., (Western Ontario '73), Adjunct Professor, Neurology

Cross Appointments
HARVEY, S., Ph.D. (Leeds '77), Associate Professor, Endocrinology/Metabolism

Departures
ALLAN, S.J., Clinical Lecturer, General Internal Medicine - (Leave of Absence)
BRETSCHER, P.A., Associate Professor, Rheumatology, to Univ of Saskatchewan
KRANTZ, M., - Medical Oncology - resigned to work for Biomira Inc.
SKELTON, D., Honorary Professor, Geriatrics, Resigned
YAO, L.C.H., Assistant Professor(Internal Medicine), Cardiology, Resigned

Retirements
BROWN, G.D., Professor, Endocrinology/Metabolism; Distinguished Professor, Internal Medicine
COGLON, R.B., Associate Clinical Professor, General Internal Medicine

APPENDIX II

COMMITTEES AND THEIR MEMBERSHIPS*

1975 - 1977

EXECUTIVE COMMITTEE
G.D. Molnar (Chair)
G. Goldsand
A.S. Russell
B.J. Sproule

EDUCATION
G. Goldsand (Chair)
C.H. Harley
W.M. Weinstein

RESEARCH
A.S. Russell (Chair)
E.G. King
A.B.R. Thomson

CLINICAL PRACTICE
B.J. Sproule (Chair)
P.M. Crockford
H. Jacobs
S.J.K. Lee

SUBCOMMITTEE PLANNING & ASSESSING EDUCATIONAL PROGRAMS
G. Goldsand (Chair)
C.H. Harley
W.M. Weinstein
G.F. MacDonald
W.R. Black
J.A.L. Gilbert

LONG-TERM PLANNING
J.B. Dossetor (Chair)
R.N. Eidem
R.S. Fraser
S. Kornell
G.D. Molnar
H. Rabin
R.E. Rossall
R.H. Wensel
C.J. Varvis

*Department Chairman a member of all committees ex officio

1978

EXECUTIVE COMMITTEE
G.D. Molnar (Chair)
J.B. Dossetor
G. Goldsand
R.N. MacDonald
A.S. Russell
B.J. Sproule
R.H. Wensel
J.C. Morrison
E.H. Shell

EDUCATION
R.N. MacDonald (Chair)
L.M. Anholt
G. Goldsand
C. Harley
J.C. Morrison

RESEARCH
J.B. Dossetor (Chair)
A.S. Russell
T.A. McPherson
H.R. Rabin
A.B.R. Thomson
J.C. Morrison
E.H. Shell

CLINICAL PRACTICE
B.J. Sproule (Chair)
M. Higgins
R.F. Taylor
R.H. Wensel
E.H. Shell

1979

COMMITTEE MEMBERSHIPS

EXECUTIVE COMMITTEE
G.D. Molnar (Chair)
J.B. Dossetor
G. Monckton
B.J. Sproule
J.C. Morrison
E.H. Shell

EDUCATION
B.J. Sproule (Chair)
L.M. Anholt
C.M. Bidwell
A.M. Edwards
J.A.L. Gilbert
C.H. Harley
E. Kretzul
J.C. Morrison

RESEARCH
J.B. Dossetor (Chair)
S.F.P. Man
A.S. Russell
J.C. Morrison

CLINICAL PRACTICE
G. Monckton (Chair)
A.M. Edwards
M.R. Higgins
R.F. Taylor
J.C. Morrison
E.H. Shell

ETHICS REVIEW
A.S. Russell (Chair)
G.D. Molnar
A.R. Turner
K.G. Warren

1980

COMMITTEE MEMBERSHIPS

EXECUTIVE COMMITTEE
G.D. Molnar (Chair)
J.B. Dossetor
G. Monckton
B.J. Sproule
J.C. Morrison
E.H. Shell

EDUCATION
B.J. Sproule (Chair)
K. Bowering
A.M. Edwards
J.A.L. Gilbert
J.C. Morrison

RESEARCH
J.B. Dossetor (Chair)
C.T. Kappagoda
S.F.P. Man
A.S. Russell
J.C. Morrison

CLINICAL PRACTICE
G. Monckton (Chair)
D.M. Bell
M.R. Higgins
R.F. Taylor
E.H. Shell

ETHICS REVIEW
A.S. Russell (Chair)
G.D. Molnar
A.R. Turner
K.G. Warren

1981

COMMITTEE MEMBERSHIPS

EXECUTIVE COMMITTEE
J.C. Morrison - Coordinator
J.B. Dossetor
C.T. Kappagoda
G.D. Molnar
G. Monckton
B.J. Sproule
E.H. Shell

EDUCATION
G. Goldsand (Chair)
P. Davis
A.M. Edwards
A.L.A. Fields
T. Noseworthy
A.B.R. Thomson
H. Tildesley (Chief Resident)
A.R. Turner
J.C. Morrison

RESEARCH
C.T. Kappagoda (Chair)
S.F.P. Man
A.S. Russell
J.C. Morrison

CLINICAL PRACTICE
G. Monckton (Chair)
R.L. Jones
E.H. Schloss
R.F. Taylor
C.H. Von Westarp
E.H. Shell

ETHICS REVIEW
A.S. Russell (Chair)
G.D. Molnar
A.R. Turner
K.G. Warren

1982

COMMITTEE MEMBERSHIPS

EXECUTIVE COMMITTEE
J.C. Morrison - Coordinator
J.B. Dossetor
C.T. Kappagoda
G.D. Molnar
G. Monckton
B.J. Sproule
E.H. Shell

EDUCATION
G. Goldsand (Chair)
P. Davis
A.M. Edwards
A.L.A. Fields
T. Noseworthy
T. Talbot (Chief Resident)
A.B.R. Thomson
A.R. Turner
J.C. Morrison

RESEARCH
C.T. Kappagoda (Chair)
M.G. Grace
S.F.P. Man
W.A. McBlain
A.S. Russell
J.C. Morrison

CLINICAL PRACTICE
G. Monckton (Chair)
R.L. Jones
E.H. Schloss
R.F. Taylor
C.H. Von Westarp
E.H. Shell

ETHICS REVIEW
A.S. Russell (Chair)
G.D. Molnar
A.R. Turner
K.G. Warren

1983

COMMITTEE MEMBERSHIPS

EXECUTIVE COMMITTEE
J.C. Morrison - Coordinator
J.B. Dossetor
G. Goldsand
G.D. Molnar
G. Monckton
B.J. Sproule
E.H. Shell

EDUCATION
G. Goldsand (Chair)
A.M. Edwards
A.L.A. Fields
C.H. Harley
T.W. Noseworthy
A.B.R. Thomson
A.R. Turner
R.A. Ulan
J. Yeung (Chief Resident)
J.C. Morrison

RESEARCH
J.B. Dossetor (Chair)
M.G. Grace
C.T. Kappagoda
S.F.P. Man
W.A. McBlain
A.S. Russell
J.C. Morrison

CLINICAL PRACTICE
G. Monckton (Chair)
R.L. Jones
L. Miedzinski
R.F. Taylor
C.H. Von Westarp
E.H. Shell

ETHICS REVIEW
A.S. Russell (Chair)
G.D. Molnar
A.R. Turner
K.G. Warren

1984

COMMITTEE MEMBERSHIPS

COORDINATING COMMITTEE
G.D. Molnar (Chair)
R.F. Taylor
J.B. Dossetor
A.M. Edwards
S.F.P. Man
G. Monckton
A.S. Russell
R.A. Ulan
E.H. Shell
J.C. Morrison (Coordinator)

GRADUATE EDUCATION
S.F.P. Man (Chair)
W.A. McBlain
J.C. Morrison
T. Kovithavongs
G. Brittain - Secretary

CLINICAL PRACTICE
G. Monckton (Chair)
P. Davis
F.A. Herbert
L.J. Miedzinski
R.F. Taylor
C.H. Von Westarp
E.H. Shell - Secretary

UNDERGRADUATE EDUCATION
R.A. Ulan, Chair
A.L.A. Fields
J.A.L. Gilbert
J. Ginsberg
G. Goldsand
Mr. T. Dewhurst (Student rep)
J.C. Morrison (Secretary)

ETHICS
A.S. Russell, Chair
Ms. L. Fester (UAH)
G.C. Man
D.W. Morrish
M.J. Poznansky
Mrs. L. Swift (lay person)
P.M. Venner
J.W. Warnica
Ms. G. Brittain - secretary

RESEARCH
J.B. Dossetor (Chair)
M.G. Grace
C.T. Kappagoda
S.F.P. Man
W.A. McBlain
A.B.R. Thomson
F.X. Witkowski
J.C. Morrison - Secretary

1985-1986

COMMITTEE MEMBERSHIPS

COORDINATING COMMITTEE

G.D. Molnar (Chair)
A.M. Edwards
S.F.P. Man
G. Monckton
R.F. Taylor
R.A. Ulan
Messrs: J.C. Morrison (Secretary)
E.H. Shell

UNDERGRADUATE EDUCATION

R.A. Ulan (Chair)
A.L.A. Fields
D. Fulton
J. Ginsberg (Secretary)
E. York
Ms. L.S. Calhoun (Student Rep)
C.H. Harley
G.F. MacDonald
J.C. Morrison

CLINICAL PRACTICE

P. Davis (Chair)
S. Allan
F.A. Herbert
R.L. Jones
M.J. Mant
L.J. Miedzinski (Secretary)
R.F. Taylor
C.H. Von Westarp
E.H. Shell

GRADUATE EDUCATION

S.F.P. Man (Chair)
W.A. McBlain
T. Kovithavongs
J.C. Morrison
G. Brittain (Secretary)

RESEARCH

J.B. Dossetor (Chair)
S.F.P. Man
M. Grace
C.T. Kappagoda
F. Witkowski (Secretary)
J.C. Morrison

RESIDENT TRAINING

A.M. Edwards (Chair)

R.F. Taylor	E. Kretzul	D. Tusz
A.H.G. Paterson	P. Chik	Ms. J. Murphy (Secretary)
D.L.J. Tyrrell	W.J. Dickout	
K. Bowering	D. Devaraj	
I. Ferguson	T. Noseworthy	
V. Chichak	T.K. Lee	

Appendix III

CHIEFS OF MEDICINE AFFILIATED TEACHING HOSPITALS*

1975:	Royal Alexandra:	W.R. Black
	Edmonton General:	G.F. MacDonald
	Misericordia:	J.V. Williams
	Cross Cancer:	T.A. McPherson
	Charles Camsell:	C.H. Harley
1977:	Royal Alexandra:	J.M. Goodhart
	Edmonton General:	R.N. Eidem
1980:	Royal Alexandra:	A.F. Wilson
	Edmonton General:	L.N. Takats
	Misericordia:	S. Weisz
	Charles Camsell:	D.J. Tusz acting
1981:	Edmonton General:	J.T. McCaffery
1983:	Royal Alexandra:	R.J. Bailey
	Edmonton General:	J.T. McCaffery and Dr. G.F. MacDonald (shared duties)
1984:	Misericordia:	M.G. Nutting
1985:	Cross Cancer:	A.L.A. Fields

*showing only 1975 and changes thereafter

Appendix IV

DIVISIONAL DIRECTORS*

1975:
Cardiology: R.E. Rossall
Dermatology: J. Brown
Endocrinology & Metabolism: P. Crockford
Gastroenterology: R.H. Wensel
General Internal Medicine: L.M. Anholt
Hematology: M.J. Mant (acting)
Immunology & Nephrology: J.B. Dossetor
Infectious DIseases: G. Goldsand
Medical Oncology: T.A. McPherson
Neurology: G. Monckton
Pulmonary Medicine: B.J. Sproule
Rheumatology: J.S. Percy

1976:
Neurology: D.R. McLean

1977:
General Internal Medicine: A.M. Edwards
Hematology: J. Hill
Pulmonary Medicine: E.G. King (acting)

1978:
Infectious Diseases: D.L.J. Tyrrell (Acting)
Pulmonary Medicine: B.J. Sproule

1979:
Cardiology: R.F. Taylor (acting)

1981:
Gastroenterology: R.W. Sherbaniuk (acting)

1982:
Hematology: N. MacDonald (acting)

1984:
Dermatology: E. Schloss
Hematology: A.R. Turner
Infectious Diseases: D.L.J. Tyrrell

1985:
Medical Oncology: A.L.A. Fields

1986:
Medical Oncology: N. MacDonald
Gastroenterology: A.B.R. Thomson

*showing only 1975 and changes thereafter

Appendix V

CHIEF MEDICAL RESIDENTS

1977 - SWITZER, C., M.D., (Alberta '75)
77/78 - ROMANOWSKI, B., M.D., (Alberta '73)
78/79 - RAMADAN, M., M.D., (Scotland '71)
79/80 - KRETZUL, E., M.D., (Alberta '73)
80/81 - BOWERING, K., M.D., (Memorial '77)
81/82 - BURGESS, E., M.D., (Manitoba '76)
82/83 - TALBOT, T., M.D., (Saskatchewan '78)
83/84 - YEUNG, J., MB ChB (Glasgow '77)
84/85 - AHMED, I., MB ChB (Manchester '77)
84/85 - STELJES, A., M.D., (Toronto '79)
85/86 - O'KELLY, B., MB ChB (Dublin '78)
85/86 - JOFFE, M., M.D., (Calgary '82)

Appendix VI

RECOGNITION OF TEACHING EXCELLENCE*

1974 A.M. Edwards
1975 A.M. Edwards
1976 A.M. Edwards
1977 A.M. Edwards (Phase III) and M.R. Higgins (MSA Teacher of the Year)
1978 H.R. Rabin
1979 J.A.L. Gilbert and D.L.J. Tyrrell (Phase II)
1980 D.L.J. Tyrrell (Phase II) and J.A.L. Gilbert (Distinguished Teacher)
1981 G. Goldsand (Phase II)
1982 A.L.A. Fields (Phase III)
1983 A.L.A. Fields (Phase III)
1984 P.M. Crockford and R.L. Jones (Phase I) and J.A.L. Gilbert (Phase III)
1985 R.L. Jones and E.G. King (Phase II)
1986 A.B.R. Thomson and T.K. Lee (Phase III)

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*Recognition by Students

Appendix VII

HONOURS AND AWARDS

1975

EDWARDS, A.M.	Governor for Alberta, American College of Physicians
FRASER, R.S.	H.K. Detweiler Travel Fellowship, Royal College of Physicians & Surgeons of Canada
	Senior Research Fellow, Department of Medical Cardiology, University of Glasgow Scotland
KING, E.G.	Regional Governor - American College of Chest Physicians

1976

THOMSON, A.B.R. Medal in Medicine, Royal College of Physicians & Surgeons of Canada

1977

FRASER, R.S.	Achievement Award, Government of Alberta - Excellence in Medicine
	Governor, Western Prairie Provinces - American College of Cardiology
HILL, J.R.	President - Alberta Society of Pathologists
IRVING, D.W.	President - Alberta Medical Association
MacDONALD,R.N.	Queen's Jubilee Medal
ROSSALL, R.E.	Consultant in Cardiology to the Minister of Hospitals and Medical Care
SCHAEFER, O.	Received the Earle Willard McHenry Award of the Nutrition Society of Canada for 1977
WILSON, A.F.	President - Alberta Neurological Society
	President - Prairie Neurosciences Society
WILSON, D.R.	Honorary Fellowship - Royal Australasian College of Physicians

1978

ELLIOTT, J.F.	Queen's Jubilee Medal and is first Distinguished Clinical Professor of Medicine
GILBERT, JAL	1978 Alberta Achievement Award for Excellence in Medicine
HILL, J.R.	President, Alberta Society of Pathologists
IRVING, D.W.	President, Alberta Medical Association
KING, E.G.	Governor, American College of Chest Physicians
MAN, S.F.P.	The S. Sproule Award of the Canadian Cystic Fibrosis Foundation
RUSSELL, A.S.	H.K. Detweiler Travel Fellowship, RCPS(C)
WEINSTEIN, W.M.	President, Canadian Association of Gastroenterology

1979

DOSSETOR, J.B.	Medical Distinction Award, Kidney Foundation of Canada
ELLIOTT, J.F.	Alberta Achievement Award for Excellence in Medicine
JONES, R.L.	President, Alberta Thoracic Society
JUGDUTT, B.I.	Canadian Cardiovascular Society Research Award
SPROULE, B.J.	Alberta Governor, American College of Physicians
WENSEL, R.H.	President, Alberta Society of Specialists in Internal Medicine

1980

HARLEY, C.H.	President, Alberta Society of Specialists in Internal Medicine
JONES, R.L.	President, Alberta Thoracic Society
McLEAN, D.R.	President, Alberta Parkinson's Society
ROSSALL, R.E.	President, Canadian Cardiovascular Society
THOMSON, A.B.R.	Editor, Journal of the Canadian Foundation for Ileitis and Colitis
WILSON, A.F.	President, Alberta Neurological Society

1981

BROWN, J.	President, Canadian Dermatology Association
FRASER, R.S.	President, Alberta Cardiovascular Society
GILBERT, J.A.L.	Chairman, Editorial Board, Medicine North America
HARLEY, C.H.	President, Alberta Society of Specialists in Internal Medicine
JAMPOLSKY, N.	President, Alberta Dermatology Association
KING, E.G.	Governor for Alberta, American College of Chest Physicians
McLEAN, D.R.	President, Alberta Parkinson's Society
McPHERSON, T.A.	President, Alberta Medical Association
ROSSALL,R.E.	President, Canadian Cardiovascular Society
SPROULE, B.J.	Governor for Alberta, American College of Physicians

1982

MacDONALD,R.N.	Distinguished Service Certificate, American Society of Oncology
McPHERSON, T.A.	President, Alberta Medical Association
MONCKTON, G.	Certificate of Merit, Muscular Dystrophy Association of Canada
ROSSALL, R.E.	President, Canadian Cardiovascular Society
THOMSON, A.B.R.	Editor, Canadian Foundation for Ileitis and Colitis Journal

1983

BROWN, G.D.	Appointed Distinguished Clinical Professor of Medicine, University of Alberta
GROOT, D.W.	President, Canadian Dermatological Laser Research and Surgery Association
KING, E.G.	President, Canadian Critical Care Society
LEUNG, W.C.	Honorary Research Professorship, Chinese Academy of Medicine
MOLNAR, G.D.	President, Canadian Association of Professors of Medicine
WILSON, A.F.	President, Neurological Society of Alberta

1984

BROWN, G.D.	Province of Alberta Frederick D. Haultain Prize in the Humanities
DOSSETOR, J.B.	President, Canadian Transplantation Society
GILBERT, J.A.L.	President, Canadian Society for Internal Medicine Governors for Alberta, American College of Physicians
GROOT, D.W.	President, Canadian Association for Laser Medicine and Surgery
KING, E.G.	President, Canadian Critical Care Society
KRETZUL, E.M.	President, Alberta Society of Specialists in Internal Medicine
MAN, G.C.	President, Alberta Thoracic Society
McPHERSON, T.A.	President, Canadian Medical Association
RUSSELL, A.S.	President, Canadian Rheumatology Association
TALPASH, O.S.	President, Alberta Association of Dermatologists
WILSON, A.F.	President, Alberta Neurological Society

1985

HEULE, M.K.	President, Alberta Critical Care Society
MOLNAR, G.D.	Chairman, Clinical & Scientific Section, Canadian Diabetes Association
RUSSELL, A.S.	President, Canadian Rheumatology Association
SPROULE, B.J.	Vice-President (Medicine), Royal College of Physicians and Surgeons of Canada
TALPASH, O.S.	President, Alberta Society of Dermatologists
TYMCHAK, W.J.	Dr. J. Dvorkin Scholarship in Cardiology
WILSON, A.F.	President, Alberta Neurological Society

1986

DAVIS, P.	President, Northwest Rheumatology Association
DICKOUT, W.J.	President, Alberta Thoracic Society
HEULE, M.K.	President, Alberta Society of Intensive Care Physicians
KAPPAGODA,C.T.	Benians Fellowship to St. John's College, Cambridge for 1988
KING, M.	Schering Travelling Fellowship of the Canadian Society for Clinical Investigation
LEUNG, W-C	President, International Biotechnology Research Society
MOLNAR, G.D.	Chairman, Clinical & Scientific Section, Canadian Diabetes Association
SPROULE, B.J.	President, Physicians for Social Responsibility
TALPASH, O.S.	President, Alberta Society of Dermatologists
TRAYHURN, P.	Andre Mayer Award of the "Instituzions Per Lo Studio Dell Obesita Italia": September 1986 - Jersualem

APPENDIX VIII*

University of Alberta Department of Medicine

Compensation of Part-Time Staff

Part-time staff are paid on the basis of the quality of their teaching, their past service to teaching, and the quantity of present teaching. The first two criteria are related to rank; thus, each rank carries with it a point value. The quantity of present teaching is arrived at by assigning each staff member various points during the year based on what category of teaching or administration he fits into in any given month. Points are assigned dollar values which may differ from year to year depending upon teaching needs and the amount of money made available by the University to compensate part-time staff. There are three documents which govern this system: (a) "Rank Compensation for Part-time Staff"; (b) "Teaching Time Categories for Part-time Staff", and (c) "Calculation and Recommendation of Salary for Part-time Staff".

The Chief of Medicine assigns points to each part-time staff member in early June of each year on the basis of the previous 12 months' activities of the staff member; the staff member is paid a lump sum for the past year at the end of July. Assignment of points can vary from year to year depending upon how active the staff member has been in teaching. The assignment of compensation points is done by the Department Chairman (a) on the recommendation of the Chief of Medicine at an affiliated teaching hospital and (b) on the recommendation of the appropriate divisional director of staff who work at the University of Alberta Hospital.

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*As reported in the 1984 PACCR Self-Study Report

APPENDIX VIIIB

University of Alberta Department of Medicine

Rank Compensation for Part-time Staff

Clinical Professor	10 points/yr.
Associate Clinical Professor	8.5 points/yr.
Assistant Clinical Professor	5.5 points/yr.
Clinical Lecturer	4.0 points/yr.
Clinical Instructor	2.5 points/yr.

Value of one point for 1983-84 = $100

5 November 1982

APPENDIX VIIIC

University of Alberta Department of Medicine

Teaching Time Categories for Part-time Staff

Category	Description	Potential Annual ÷ 400 Salary Points	Actual Annual ÷ Stipend Points	Actual Monthly Stipend Points
A	Intensive scheduled bedside teaching rounds and evaluation of students and residents 3 or more times per week; one or more seminars or other didactic sessions per week; always available to students and residents; considerable incidental teaching during unscheduled ward rounds.	20,000 (÷400=)	50 (÷10=)	5
B	Regularly scheduled bedside teaching rounds and evaluation of students and residents 3 or more times per week; 1 or more seminars or other didactic sessions per week.	16,000 (÷400=)	40 (÷10=)	4
C	Regularly scheduled bedside teaching rounds and evaluation of students and residents 3 or more times per week.	10,000 (÷400=)	25 (÷10=)	2.5
D	Incidental teaching during unscheduled ward rounds; occasional seminars; or preceptor for elective students in office or hospital setting.	5,000 (÷400=)	12.5 (÷10=)	1.25
E	Little or no teaching	0	0	0
F	Acts as Chief of Medicine, (Admin)	12,500 (÷400=)	31.25(÷10=)	3.125
G	Presentation of a lecture or teaching to a small group in Phase 1, Phase II or the whole class lecture series in Phase III		1 per time	
H	Educational director (Admin)	5,000 (÷400=)	12.5 (÷10=)	1.25

Value of 1 point for 1983-84 = $100
5 November 1982

APPENDIX VIIID

University of Alberta Department of Medicine

Calculation and Recommendation of Salary for Part-time Staff

Re: Dr. _____ Hospital _____

A. Rank compensation

Rank is _____

Stipend for rank is: _____ (rank points) x _____ (value of 1 point) = $_____ (a)

B. Time compensation

		Points per Time Period											
A - E	Clinical Teaching	July/ Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May/ June	Total Points for Year	Year's Stipend
G	Lecturing												
F, H	Admin.												
											Totals		(b)

(a) Rank compensation + (b) Time compensation = Stipend for one year

_____ + _____ = _____

_____ _____

Date Chief of Medicine

DATE DUE SLIP

F255 O